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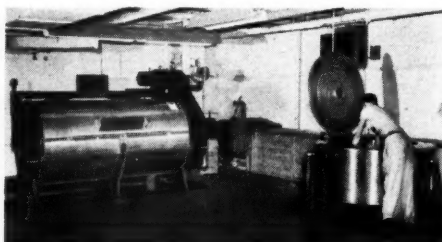


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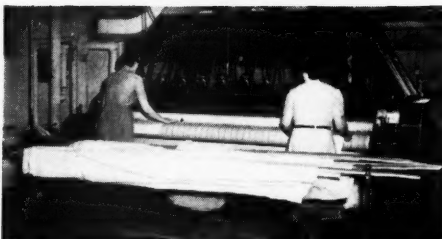
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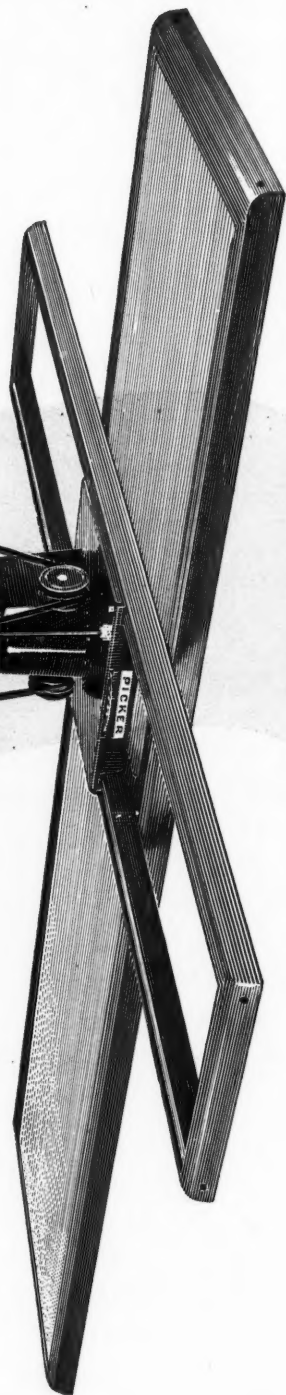
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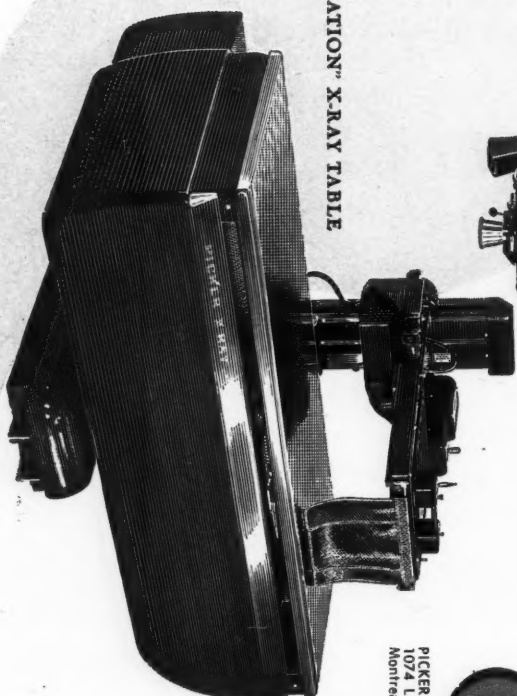
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◀ Notes About People ▶

Harvey E. Taylor, a Director Canadian Hospital Association

(This is the 11th of a series of biographical notes, introducing officers and directors of the Canadian Hospital Association for 1955-57)

Harvey E. Taylor, administrator of the West Coast General Hospital, Port Alberni, B.C., was elected to the Board of Directors of this association at the 13th biennial meeting, held in May 1955; and, at the same time, he became a member of its Committee on Constitution.

Born in Nanaimo, B.C., Mr. Taylor resided for some 18 years in Calgary, Alta., where he received his elementary and high school education. He attended the University of Alberta in 1920-21 and subsequently spent several years in the United States. For two years he lived in Rhode Island and for five in North Carolina where he was employed by a large textile company. In 1930 he became interested in hospital work and was associated for a number of years with a private hospital in Ashville, N.C.

Upon his return to Canada in 1940, Mr. Taylor was appointed administrator of the Powell River General Hospital and took an active part in planning the new hospital which was opened in 1942. In 1946, he accepted the post of administrator at the West Coast General Hospital, Port Alberni, B.C., and shortly thereafter was busily



Harvey E. Taylor

engaged in preliminary planning for the new 111-bed hospital which was opened in 1952. For two years he was chairman of the campaign committee which raised funds to help cover the costs of construction. Harvey Taylor has thus been involved in the building and equipping of two new hospitals — a unique experience which comes to but few administrators.

Long active in the affairs of the British Columbia Hospitals' Association, Mr. Taylor served as its vice-president for two terms, 1951 to 1953, and as president from 1953 to 1955. He was a member of its directorate, as a regional representative, for many years and chaired various committees, e.g., the Resolutions Committee in 1951-52. He was active in the formation of the Association of Hospital Administrators of British Columbia and is a charter member of that organization.

It was while Harvey Taylor was president of the British Columbia Hospitals' Association that the government of that province, through the Ministry of Health and Welfare and the Hospital Insurance Service, notified all hospitals in the province, by means of circular 55-7, that any increase in wages and salaries over and above the 1954 approved level would become the responsibility of the hospital board concerned. The reaction of the association to this circular was set out in Mr. Taylor's presidential address at the annual meeting, held in Vancouver, October, 1955 (see *The Canadian Hospital*, January, 1956, Page 41).

Having a constant interest in community affairs, Mr. Taylor is this year president of the Rotary Club of Port Alberni. He is particularly concerned with projects related to recreation for young people and children. His hobby is gardening. While he does not claim to be an expert in this field, he enjoys working out-of-doors and observing the growth of plant life.

Retires From Riverview Hospital Post

Dr. John M. Nettleton, superintendent of Riverview Hospital in Windsor for the past three years, retired from that post as of last month but remains

with the hospital in a consulting capacity until June. His successor is J. S. Lockie, formerly business administrator of the hospital. At the same time, Dr. Clifford M. Keiller, formerly medical assistant to the superintendent, was named director of medical services.

The board of governors of Riverview hospital have paid high tribute to Dr. Nettleton for his work in administering the hospital during a period of reorganization, giving him much credit for improving the hospital's standing in the community. A veteran of World War I, Dr. Nettleton was recalled to duty during World War II with the rank of lieutenant-colonel and became commanding officer of Rideau Military Hospital in Ottawa. Later, moving to the Department of Veterans Affairs, he became superintendent of Deer Lodge Hospital in Winnipeg, retiring from the Civil Service in 1952. Dr. Nettleton is a graduate of the University of Toronto.

Appointed Consultant

Dr. Gaston Loignon, medical superintendent of Hôpital St-Jean de Dieu in Montreal has announced the appointment of Dr. Lucien Larue as consulting physician to that hospital. Dr. Larue is medical superintendent of Hôpital Saint-Michel-Archange at Mastai (near Quebec) and of the psychiatric hospitals at Roberval, Baie St. Paul, and St. Ferdinand, in that province. He is also chairman of the department of psychiatry at Laval University and medical director of Hôtel-Dieu de Québec in Quebec City. Dr. Larue's outstanding position in the health field in his province is reflected in his appointment last year as a member of the Quebec Hospital Commission. His appointment at Hôpital St-Jean de Dieu gives that hospital a highly valued link with Laval University.

Alberta Tuberculosis Association Appoints Nursing Service Consultant

Edna Carveth, R.N., has joined the staff of the Alberta Tuberculosis Association as nursing service consultant. Her services will be available, in an advisory capacity, to assist nurse training schools and public health nurses in matters related to tuberculosis. Miss Carveth is a graduate of the Royal Alexandra Hospital School of Nursing in Edmonton; and studied public health nursing at the University of Toronto. In her new post she replaces Mrs. Winnifred Norquay, R.N., who resigned to accept the newly created

(Continued on page 16)

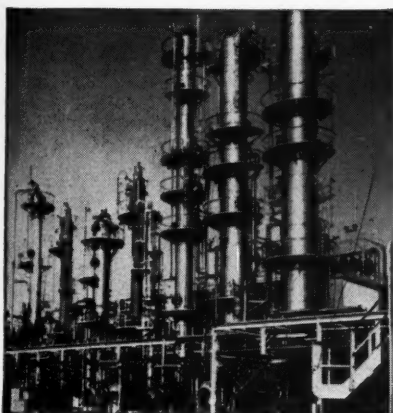
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'Teepol' is used in various processes in the engineering and metallurgical industries, it is highly recommended for aqueous degreasing either through immersion, drum washing, spraying or electrolytic methods.

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PAUL J. AMMANN
Chemical Research Director

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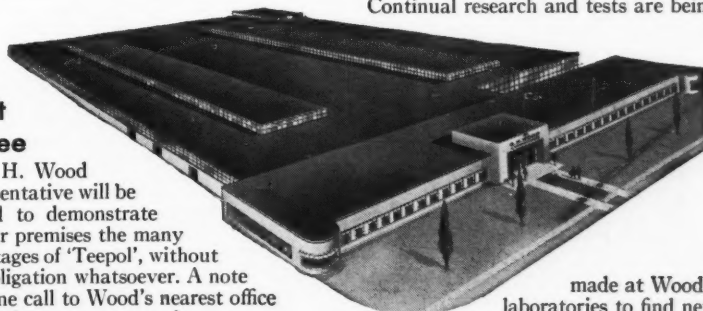
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Where 'Teepol' is Processed

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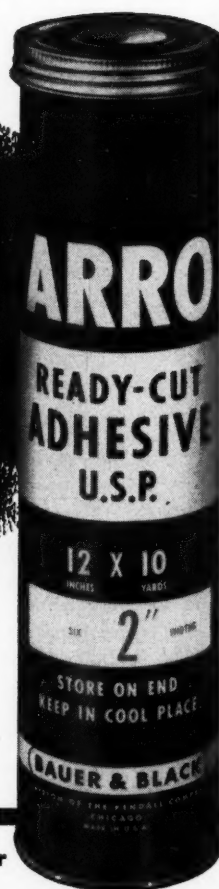
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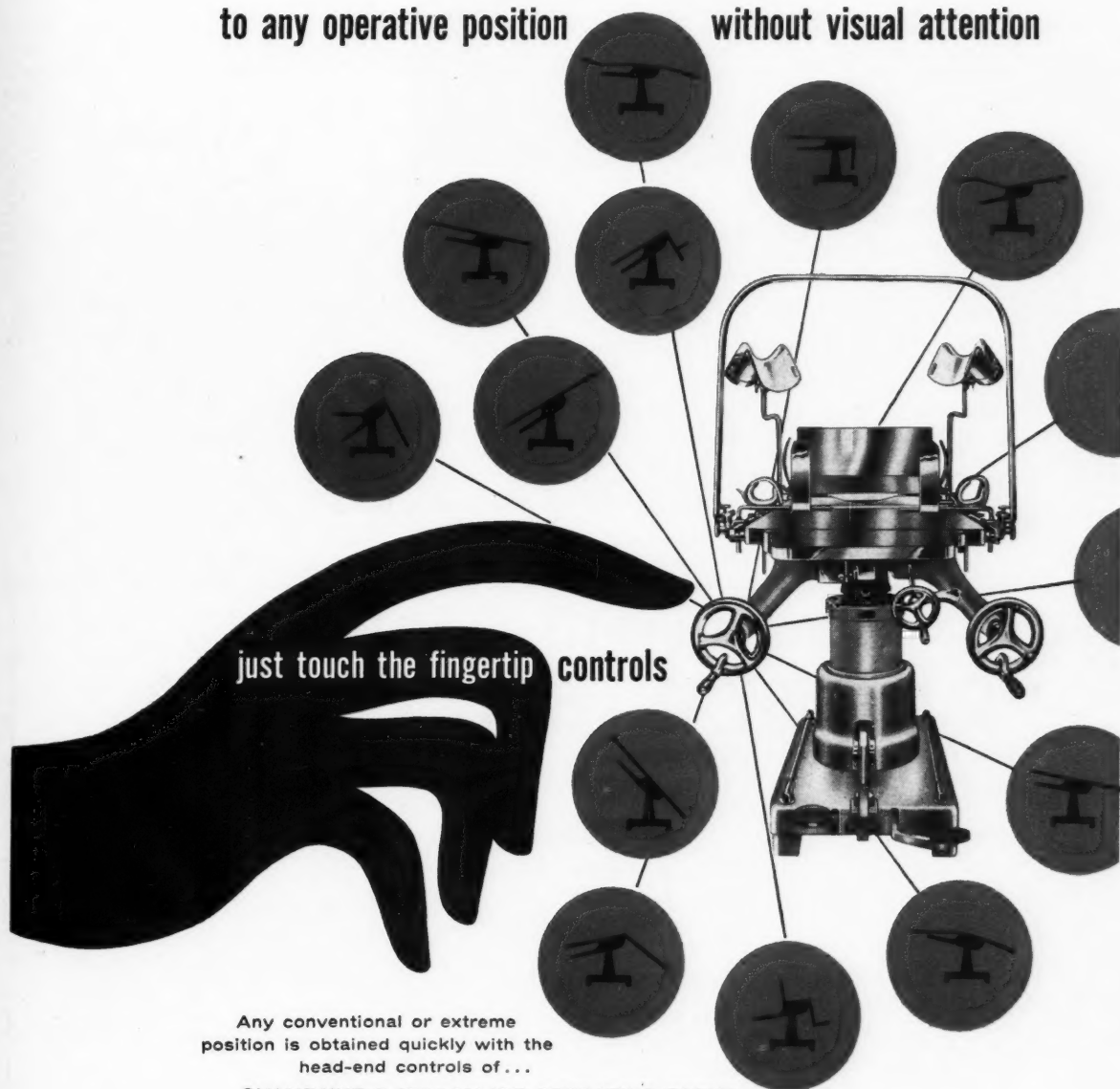
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Notes About People
(Continued from page 12)

post of supervisor of field nurses, Directorate of Indian Health Services, Department of National Health and Welfare, Ottawa.

**Member of Governing Board
Appointed Administrator**

A. E. Davidson of Midland, Ontario, has been appointed administrator of St. Andrew's Hospital, Midland, succeeding Miss M. E. Ingham who retired from that post. Mr. Davidson who was previously office and personnel manager of a commercial firm had also been a member of the hospital's governing board and its secretary. These posts he resigned upon becoming administrator.

**Director of Laboratories
Appointed for Two Hospitals**

Dr. E. L. Barton has been appointed director of laboratories for Guelph General Hospital and St. Joseph's Hospital in Guelph. Born in London, Ont., Dr. Barton was graduated in medicine from the University of Western Ontario, in the same city, in 1937, and also undertook postgraduate studies there. In 1939 he joined the staff of



Dr. E. L. Barton

the Ontario Department of Health; and from 1946 to 1950 he held the post of director of laboratories for that department. From 1950 until his recent appointment at Guelph, he was assistant pathologist at Kitchener-Waterloo Hospital, Kitchener, Ont., during which time he also did work in pathology for Guelph General and for South Waterloo Memorial Hospital at Galt.

New pathology and bacteriology laboratories have now been set up at

Guelph General Hospital and Dr. Barton will serve that hospital and St. Joseph's on alternate days.

New Superior at Cranbrook

Rev. Sister John of the Passion, formerly of Kenora, Ont., is now superior of St. Eugene Hospital at Cranbrook, B.C. She replaces Sister Therese Amable who has been transferred to Iacombe Home at Midnapore, Alta., as sister superior there. Hospital employees honoured Sister Therese Amable at a farewell party prior to her departure.

**Director General of
Treatment Services**

The Hon. Hugues Lapointe, Minister of Veterans' Affairs, has announced the appointment of Brig. J. N. B. Crawford, M.B.E., E.D., M.D., as Director General of Treatment Services, succeeding Dr. W. P. Warner who died in December last. In recent years, Brig. Crawford has been executive staff officer of the Canadian Forces Medical Council, Department of National Defence. Born in Winnipeg, he was graduated in med-

(Continued on page 22)

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(Continued from page 16)

icine from the University of Manitoba in 1930 and, after two years' post-graduate study in paediatrics, he set up practice in Winnipeg. His military career began when he was commissioned as a lieutenant in the R.C.A.M.C. in 1933 and he was called into active duty in 1939. In 1941, then with the rank of major, he was posted to Hong Kong and, along with other Canadians, was taken prisoner by the Japanese. Since his return to Canada in 1945, his career has been one of continued promotion within the armed services and his new position is one of honour and great importance.

Robena Williams Glass

Superintendent of the Charlotte Eleanor Englehart Hospital at Petrolia, Ontario, Mrs. Robena Glass died recently after an illness of several months. A graduate of the Regina General Hospital School of Nursing, Mrs. Glass joined the staff of the hospital in Petrolia in 1946 as assistant superintendent, becoming superintendent two years later. She was highly respected by staff members and had a wide circle of friends in the surrounding community.



Sister Juliette Barcelo, r.h.s.j.

Elected president* of La Conférence de Montréal de l'Association des Hôpitaux Catholiques du Canada in April, 1955, Sister Juliette Barcelo is a member of the staff of Hôtel-Dieu-de-Montréal, Montreal, P.Q. A dietitian by profession, she was superior of Notre-Dame Hospital, Biddeford, Maine, from 1948 to 1952. She has been secretary of the Association of Nurses of the Province of Quebec, District XI, and a member of the Commission Universitaire des Gardes-malades.

* For other presidents of Catholic Conferences see "The Canadian Hospital", April, page 41.

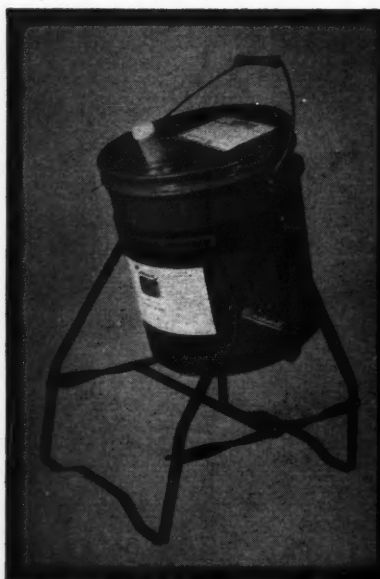
William M. Ferguson

A well-known architect who had worked on hospital designs in almost every Canadian province, William M. Ferguson of Toronto died last month at the age of 73. Born in Scotland, he received his professional training in Glasgow and came to Canada in 1911. Among his many projects throughout the years, he had charge of planning and designing the Sun Life Building in Montreal and he designed the Cenotaph at Toronto City Hall. For many years he has been a senior member of the architectural firm, Govan, Ferguson, Lindsay, Kaminker, Langley, and Keenleyside, Toronto.

• F. P. Chaffey who has been business manager of Ongwanada Sanatorium, Kingston, Ont., for the past seven years, has been appointed administrator of the Cottage Hospital at Pembroke, Ont. In his new post, he replaces Marjorie Hawkins who resigned to accept the position of superintendent at Chesley and District Memorial Hospital, Chesley, Ont.

• Elizabeth Klein of Toronto has been appointed superintendent of Huntsville Memorial Hospital, Hunts-

(Concluded on page 112)



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W. Douglas Piercey, M.D., Editor



Obiter Dicta

A New Name Please!

WHY DOES the term "incurable" still appear fairly often in the official name of a hospital? Today, with a more hopeful and progressive outlook toward recovery from illness, should there not be a change in name to correspond? Now, with the increasing emphasis on rehabilitation, the discovery of new methods of treatment, the greater use of physiotherapy, occupational therapy and psychotherapy, more long-term illnesses are being brought within the orbit of curative therapeutics. In many other conditions, it has been shown that adequate treatment can hold out hope for much improvement.

Medical progress is proceeding so rapidly today that there is no justification for retaining the term "incurable" within the titles of institutions caring for long-term patients. Some of the conditions for which medical science can offer no cure at the present time may be curable in the near future. Even if they are not, from a psychological point of view, the effect is harmful to the patients' morale when they are told they must go to a hospital for incurable diseases. There is something so final and so depressing in the term. It is not in keeping with the care and treatment offered by hospitals for long-term patients today.

While the terms "chronic" or "long-stay" are much to be preferred to "incurable", why use any of these words in the titles of institutions? Why not choose a name which has no relation to the type of care offered—one that will in no way be associated by patients with their illness.

Trustees and other lay hospital people are sometimes too prone to consider that the term "acute illness" is synonymous with curable disease and "chronic illness" with incurable disease. Yet an acute illness may have a fatal termination and many patients with a chronic illness may, eventually, be cured or at least show signs of improvement. The artificial distinction between acute and chronic hospitals is becoming less discernible with the passing of every year.

Today, with an increasing proportion of the population in the age group where long-term illnesses are most preva-

lent and with more interest directed toward the study of these conditions, let us hope that greater attention will be given to choosing a name for institutions which in no way can be construed as labelling the patients as hopeless cases. Even if it requires a change in by-laws or charter, a change in name is indicated in order to keep up with present-day advances in medical and social sciences.

La Révision de "CHAM"

UNE notice portant le titre "Opération CHAM" a paru dans notre numéro du mois d'octobre 1951. Dans les quelques mois suivants, le Manuel de Comptabilité des Hôpitaux du Canada a été compilé et imprimé. Peu après le premier anniversaire de sa publication, le docteur O. C. Trainor, dans son discours présidentiel à la deuxième réunion biennale du Conseil des Hôpitaux du Canada, a dit, entre autre: "Je pense que ce n'est pas une exagération de dire qu'il n'y a eu aucun projet du Conseil depuis son inauguration qui aura probablement un effet si profond et durable que ce même CHAM". (Canadian Hospital Accounting Manual).

Dans les années intermédiaires, ce sentiment a été réitéré maintes fois. De tout ce que nous avons vu et entendu dire, il nous reste simplement à tirer la conclusion que le manuel de comptabilité a rendu un grand service aux hôpitaux du Canada.

Comme tout autre oeuvre semblable, le manuel de comptabilité n'est pas "à l'épreuve du temps". Des circonstances et des conditions changeantes dans le domaine hospitalier demandent des modifications appropriées dans les systèmes comptables et dans la compilation de statistiques des hôpitaux. Ce travail de révision s'effectue à un moment où les forces du progrès social au Canada se pressent constamment vers un plus haut point de développement et à un moment où il semble possible que des changements radicaux dans tout le système des finances des soins hospitaliers soient imminents. La révision du manuel attire l'attention de tout comptable, administrateur, et gouverneur d'hôpital. Nous voulons souligner l'ar-

title qui paraît à la page 66, et surtout la requête, faite à la fin de l'article, pour attirer des idées et des suggestions concernant la matière à inclure dans la seconde édition du Manuel de Comptabilité des Hôpitaux du Canada.

Your New Hospital Directory

THE 1956 *Canadian Hospital Directory* is now available. Published annually since 1953, this year's edition contains all the sections included last year as well as an additional one on hospital accreditation. This latter division should prove of value to administrators, trustees, chiefs of staff and others who are concerned with details of the accreditation program. It includes explanatory data and survey forms which have recently been revised by the Joint Commission on Accreditation of Hospitals. Information regarding the library service of the Canadian Hospital Association and sources of visual aids (first published in the 1955 directory) have been retained; but the list of textbooks available from the library and a sample list of films has not been repeated. New books acquired by the library will be listed from time to time in *The Canadian Hospital*.

Tables indicating the number of hospitals in Canada, number of beds, and related information, are again included. These figures are not intended to supplant the much more comprehensive statistics published annually by the Dominion Bureau of Statistics under the title *Hospital Statistics—Volume I*. Anyone interested in statistical studies on a national scale should use the D.B.S. reports. Nevertheless, we believe the tables included in the directory are extremely useful and provide a valuable supplement to the official statistics. This is partly because the figures are up-to-date almost to the month of publication (May); and also because all hospitals, public, private, and governmental, are included, whether or not they have reported directly. The information in the tables is supplied mainly by the hospitals themselves, supplemented and checked through a variety of sources.

While the section providing data on individual hospitals includes many nursing homes and other institutions on the borderline between hospitals and welfare homes, only hospitals are included in the tables. However, the tables do list 3,898 beds for the infirm and 2,777 beds classified as domiciliary, where the institutions concerned have a preponderance of beds for general, mental, tuberculosis or other type of treatment.

The tables show there are 1,422 hospitals of various types and sizes in Canada which have 188,934 beds. These include 832 public general hospitals with 79,117 beds; 196 public special hospitals with 88,986 beds; 251 private hospitals with 6,056 beds; and 143 federal institutions with 14,775 beds. Of the 188,934 beds tabled for all of Canada, 84,966 are classified as general; 62,586 as mental; 18,402 for the care of tuberculosis patients; and 9,543 for the care of long-term patients. The remainder are in some one of the following categories: contagious, convalescent, orthopaedic, miscellaneous, infirm, or domiciliary.

Table No. 2 shows very clearly that, numerically, the majority of the 1,422 hospitals in Canada are under 50 beds in size. There are 175 in the 1-9 bed category; 368 in the 10-24 bed group; and 287 in the 25-49 bed group, for a total of 830 hospitals in the first three categories. There are 190 in the 50-99 bed size; 183 in the 100-199 group; 64 in the 200-299; 70 have 300-400 beds; and 85 hospitals have 500 or more beds. Table 2 gives, also, the distribution by class and ownership and shows

that there are 547 lay hospitals with 44,307 beds; 338 hospitals under religious auspices with 59,563 beds; 293 municipal hospitals with 19,430 beds; and 244 other hospitals (provincial and federal) with 65,634 beds.

The editor makes no claim that the tables are infallible; yet they are as accurate as careful interpretation of all the data available can make them. At the same time, it should be pointed out that frequently bed distribution as to type of care, interpreted from returns received, becomes a matter of opinion. Thus one person may interpret the bed distribution of a particular hospital as falling in certain categories where another could find equally valid reasons for naming the same beds as other types. This is true particularly of the categories chronic, convalescent, infirm, domiciliary, and miscellaneous.

The editor believes that, for administrative purposes, the bed figure most valuable is the number of *beds set up*. Except for the column in Table 1 headed "Rated Capacity", inserted for purposes of comparison, *beds set up* are used in the tables. The expression "set up" is self-explanatory. The term "rated capacity" represents the number of beds for which the hospital is designed. It is determined by standards of measurement established by provincial health authorities and is subject to the following minima:

Adults	— single patient room	— 100 sq. ft.
	— multiple accommodation	— 80 sq. ft.
Children	— single patient room	— 80 sq. ft.
	— multiple accommodation	— 50 sq. ft.
	— infant (excl. newborn)	— 30 sq. ft.

We take this opportunity of expressing our appreciation to all those people who have made the publication of the 1956 *Canadian Hospital Directory* feasible. The assistance of administrators, other hospital personnel, officers of allied organizations, and government officials, has been of inestimable value; and indeed the directory could not have been achieved without their active participation. The continued support of our advertisers has made it possible again to achieve an attractive format. To all concerned we extend our grateful thanks and hope that those who participated and all who use it will find the 1956 *Canadian Hospital Directory* of value in their daily work.

Legal Institute at Montreal a Success

THE MONTREAL Hospital Council is to be congratulated on the successful completion of a three-day institute on the legal aspects of medical practice and hospital administration, held April 23rd to 25th. The institute was organized by the faculty of law of McGill University in co-operation with the faculty of medicine and the Montreal Hospital Council. This institute was the second in which the Council has participated, a similar one having been held in the French language at the University of Montreal in the spring of 1955.

There is a growing demand for this type of institute, which included such topics as hospital-physician-press relationships; mode of remuneration of the hospital physician; legal responsibility of the board, the physician, and the administrator; and the importance of medical records. In addition to formal papers presented by leaders in the legal, medical, and hospital fields, a number of panel discussions were held. Some 45 persons enrolled for the meeting, the majority of whom were hospital administrators from Montreal and other parts of the province. The experience which the Montreal Hospital Council has gained in the operation of this type of institute should prove of value to the officers of other hospital associations who are contemplating similar courses.

Extended Services at the

Royal Victoria

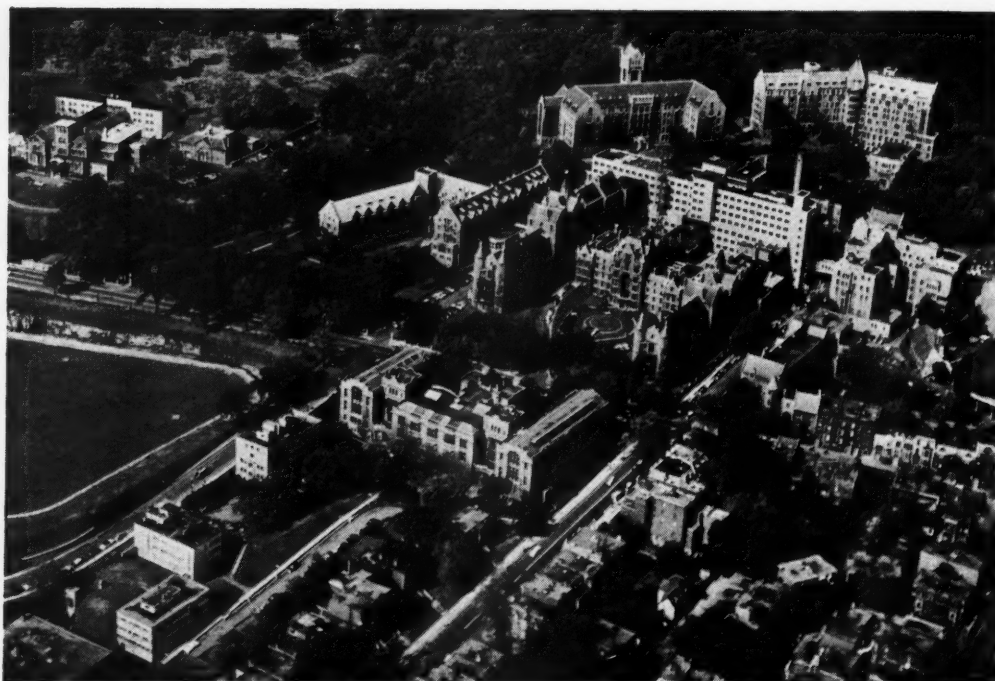


Governor-General Vincent Massey with G. Blair Gordon, President of the Board of Governors, at the official opening.

ON Friday, January 20, 1956, His Excellency the Rt. Hon. Vincent Massey, Governor-General of Canada, officially opened a new 274-bed wing at the Royal Victoria Hospital in Montreal, P.Q. This addition, which brings the hospital's present capacity to 930 beds and 115 bassinets, is the central service hub for the whole hospital, linking earlier units. The ten-storey wing, which has four floors for patients, includes new surgical and radiological facilities, a new dietary department, and other services directly and indirectly essential to good patient care. Built at a cost of nearly \$5,700,000, the wing was financed largely through contributions on the part of the public to the Royal Victoria Hospital Fund in 1951.

In the following pages we present a series of seven articles which cover the development of the "Royal Vic" since its establishment in 1887, point up the architectural problems involved in planning the new wing, and describe several of the excellent service areas now provided. We are grateful to Dr. J. Gilbert Turner, executive director of the hospital (who is also president of the Canadian Hospital Association) and to his associates who have given so generously of their time in preparing articles for this series. — *Edit.*





Extended services —

Developed through long-range planning

SUNDAY morning, December 18, 1955, was another milestone in the 60-year life of the Royal Victoria. In the space of 90 minutes some 116 patients were moved into our \$5,700,000 new wing. Having in mind the ancestry of our two founders, Lord Strathcona and Lord Mount Stephen, and the fact that the president of the Canadian Pacific Railway, by our Charter, is a governor of the hospital, it was a coincidence indeed that the first patient to be moved was a Scotsman in the employ of the Canadian Pacific Steamships. The smoothness and the quickness of the move and the comparatively small number of staff required were all evidence of good planning. The move was not without its humour or its touch of sadness. On a final check, in one of the old wards, a dear old lady was discovered in a side room peacefully asleep and oblivious to all the commotion that had been going on. A kindly old gentleman, when tucked in his new bed, was asked if he liked his new home. He replied, "No, I miss all my pals in the big ward".

Naturally, both patients and staff

**J. Gilbert Turner, M.D., C.M.,
M.Sc., F.A.C.H.A.
Executive Director,
Royal Victoria Hospital,
Montreal, P.Q.**

were somewhat over-awed initially by the newness of everything, i.e. accommodation facilities and labour-saving devices. Radical changes are not always accepted easily. Time passed, however, and when the "shakedown cruise" was over, no one would change the new for the old.

Planning for the new wing began in 1946 with the establishment, by the Governors, of a building committee of the medical board. Four years later the architects and the hospital consultant were engaged. The building committee of the medical board and the administration, together with the architects, held frequent meetings and were occasionally joined by the building committee of the Governors and the hospital consultant. In the spring of 1951, a public campaign for funds was conducted and the magnificent sum of just over \$8,000,000 was obtained from the public and from governments.

Construction began March 9, 1953.

The new wing of the Allan Memorial Institute was begun in June, 1952, and was completed late in 1953.

The original hospital, modelled after the Royal Infirmary in Edinburgh, was opened on January 2, 1894. The Ross Memorial Pavilion was occupied in 1916 and the Women's Pavilion in 1926. In 1944 the residence of the late Sir Montague Allan, on nine acres of land adjoining the hospital grounds of 26 acres, was given to the Royal Victoria and immediately converted into its department of psychiatry under the name of the Allan Memorial Institute. The first nurses' residence was built in 1907 and the second some 25 years later, about the same time as the new interns' residence. Over the years, additions to the original buildings and renovations have been made in an effort to keep abreast of medical developments; but the depression of the 1930's and the war years put a curb on these changes while, of course, new construction was entirely out of the question.

In 1946, more especially in 1948, when the intensive studies really

began, the governors and the medical board were faced with decisions of the greatest magnitude. First, the overall needs of the hospital on a long-range basis were studied and agreed upon; secondly, because of the anticipated amount of money available, priorities had to be allotted and they were as follows: semi-private accommodation, operating room facilities, kitchen and dining facilities, a new x-ray department, and central supply.

With these priorities in mind, plans were developed rapidly for the building which we now have. Throughout the planning, team work was the keynote. Sub-committees were appointed in every instance to study the special needs of each department and the department head was very much in the picture. For example, the key people in the designing of the operating room floor were the surgeon-in-chief, the anaesthetist-in-chief, the supervisor of the operating rooms and the administration. All plans were studied in detail by the building committee of the medical board and recommendations were sent periodically to the governors. Minutes were kept of every meeting of this committee and copies were sent to its members, to the governors, the architects and the consultant.

It was not an easy matter to choose

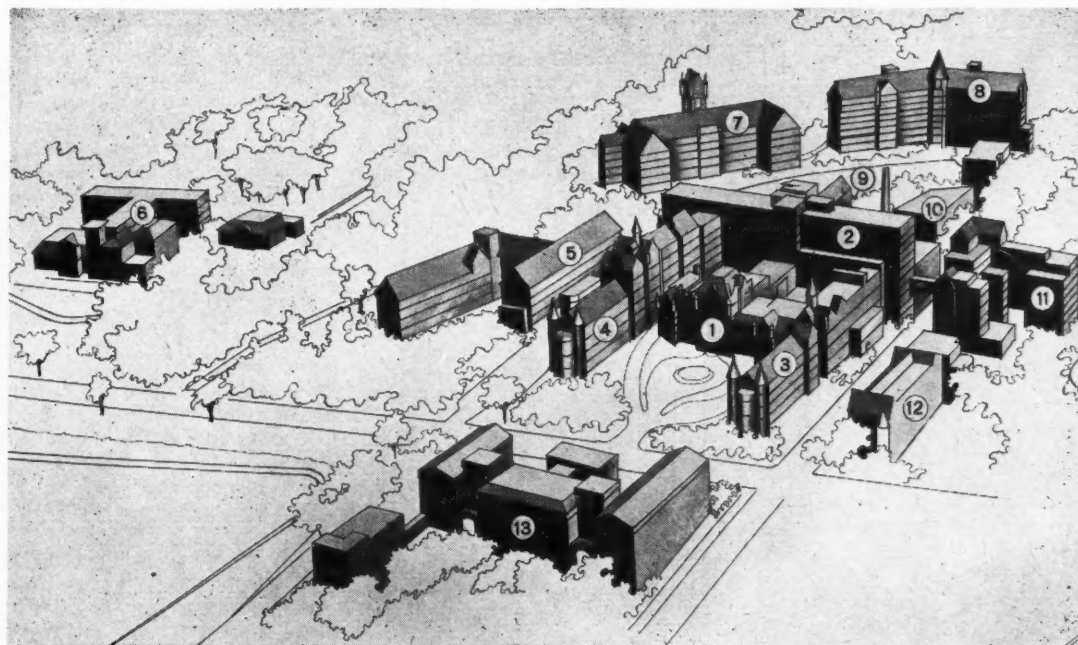
the site for the building but studies showed that there was only one place. Thus it was put in the "centre of events", so it could be connected to all pavilions (except the Allan Memorial Institute) and to the out-patient department on four floors. Height of this building was limited to ten storeys so as not to obstruct the view from the Ross Memorial and the Women's Pavilion. Because of our close relationship with the Montreal Neurological Institute, the former bridge connecting the two institutions is maintained.

Another important point was that the day-to-day work of the hospital had to continue even with blasting and construction above, below, and on all sides. I would be ungrateful if I did not mention the consideration of the above factor shown by the contractors and also the forbearance of our staff who had to work for so long amidst noise, dust, and behind barred windows. There were one or two close shaves but no untoward incident. Now that it is over, we can look back upon it as one of those experiences which comes once in a lifetime.

No longer, on entering the main front door, is one immediately stopped by the open stairway with the statue of Queen Victoria on the first landing. Now, one looks down a 300-foot cor-

ridor of marble (from the Eastern Townships) to see at the far end the statue in its new location. This is the elevator lobby of the new wing. All but 100 feet of the corridor was blasted out of solid rock without interruption of the daily routine. The first part of the corridor is widened on each side into public waiting rooms. Further on are a gift shop, a private consulting room, rest rooms and locker rooms for medical students. In the elevator lobby are four high speed elevators, each with a capacity of 27 to 30 people. One is reserved for patients while the other three are for staff and visitors. A separate elevator quite outside this bank runs from the central stores to the main kitchen and on up to the individual floor pantries and is quite inaccessible to anyone except the dietary staff.

The new wing, of modern appearance, which sits on solid rock and is finished in Queenston limestone, is essentially a surgical wing. It contains no administrative areas. The upper four floors are for patient accommodation in 60 four-bed rooms, 4 two-bed rooms, and 26 single rooms. These single rooms, comprising almost ten percent of the total beds, are evenly distributed on the four floors and are for medical needs; experience to date has



Legend

1. Administration
2. New Wing
3. Medical Wing and Outdoor Department
4. Surgical Wing

5. Nurses' Home
6. Allan Memorial Institute
7. Ross Memorial Pavilion
8. Women's Pavilion
9. Interns' Residence

10. Power House and Laundry
11. Montreal Neurological Institute
12. Pathological Institute
13. Medical Building, McGill University

proved the wisdom of providing them. Because the departments of ophthalmology, otolaryngology and urology—except for private beds—are housed entirely in this new wing, it was decided to rate the whole patient accommodation as "multiple occupancy" with one general rate schedule for all patients and with the provision that patients who ordinarily would be classed as ward patients would receive a discount from the credit department in keeping with their ability to pay.

Every consideration has been given to the comfort of the patient and to easing the load on both the doctors and the nurses. The nurse-patient communication system is located between each two beds. In each room there is a hand sink, quite separate from the enclosed toilet, an individual clothes locker, piped oxygen and piped suction between each two beds, individual pillow radio (at no extra charge), and a wall light above each bed. There is no central illumination. For each bed there are: a single pedestal overbed table, a bedside table with a pull-through shelf, a footstool, a straight chair, and a cubicle curtain. The windows are single glazed, double hung and reversible, with venetian blinds and drapes. The floors are covered with fortified linoleum and there are wide cove bases on the two walls where heads of the beds rest.

The corridors are 9 ft. 6 ins. with cove bases. The floors are of pure vinyl tile. Because of the extreme length of the building, colour tones on corridor walls change at regularly spaced intervals which, visually, is shortening in effect. Each corridor also has emergency lighting, central vacuum outlets and electrical outlets for special services.

There are two nursing stations per floor and each is centrally located on its nursing unit with an adjoining suite for the interns consisting of a chart room, dictating room and laboratory. In addition to the nurse-patient communication system, there is a pneumatic tube in each station connecting with all other nursing stations and with the various service areas. On each nursing unit there is a bathroom suite of three individual bathrooms leading off a corridor so that they may be used by both sexes.

The laundry chute on each floor is recessed behind locked doors and is at floor level. There is an adequate bay for wheel chairs and stretchers.

We were mindful of our responsibilities to teaching and so we provided adequate class room space, conference rooms and secretarial offices. The day

room on each floor is a boon to the up-patients; there is a separate waiting room for visitors.

In view of the provision of an individual pillow radio for each patient, portable radios are not permitted. Television is allowed in the day rooms only.

The special facilities of the surgical, anaesthetic, radiological, urological,

and dietary departments are described in the accompanying articles.

Additional special features include (1) a suite between the operating rooms and the recovery ward for ambulatory patients undergoing endoscopy examination. Traffic control is maintained by an information clerk at the general entrance to this floor. (2)

(Concluded on page 94)

Extended services —

An architectural feat

**Barott, Marshall,
Montgomery & Merrett,
Architects,
Montreal, P.Q.**

THE NEW wing of the Royal Victoria Hospital is a large building, 375 feet long and rising ten storeys from the lowest elevator hall to the penthouse solarium and roof deck. But, placed as it is in the heart of a group of buildings on the southern slope of Mount Royal, it is practically hidden from public view, and no aspect except from the air gives a true idea of its size.

Both the planning and construction of this new building involved the resolving of a number of unusual problems. The building, as finally developed, should not be studied without some understanding of these controlling conditions.

The main group of buildings of the hospital consists of three long wings extending back northward from Pine Avenue into the mountainside. The central wing is an inverted "T" shape. The cross of the "T" stops short of joining the east and west wings by the width of roadways that give access to the courtyards. The roadways are bridged by enclosed passages at third floor level, 25 feet above the main entrance lobby. This was the main traffic floor for access to all buildings prior to the new construction and alteration program. (The entrance lobby, at the front of the central wing, is used as the reference point for all levels given below.)

Hospital Consultant for the new building was Dr. Basil C. MacLean, New York City; the General Contractor, Angus Robertson Limited, Montreal; and Consulting Engineers, McDougall & Friedman, Montreal.

Prior to the new construction, the rear ends of the three wings terminated more or less in line. The east wing, running up University Street, ended at the hospital's power plant. The central and west wings ended against the steep hillside, which was terraced with high retaining walls to provide at its base the exit road from the two courtyards (about 12 feet above the entrance lobby). At the upper level was the entrance driveway and building of the Ross Memorial Pavilion for private patients (with its ground floor about ninety feet above the entrance lobby). At the intermediate level 85 feet north of the central wing, is the interns' residence (with its lowest floor about 30 feet above the entrance lobby).

From the rear of the central wing, at the 25-foot level, the corridor emerged as an enclosed bridge that formed the "crossroads" of the hospital. One branch plunged into the steep hillside and became a tunnel to the elevator hall 60 feet below the ground floor of the Ross Memorial Pavilion. Another connected to the interns' residence, and the third ran eastward to the arched stone bridge across University Street to the Montreal Neurological Institute. En route, this branch made a connection with the east wing. The west wing had no connection at the rear with any other building.

This steeply-sloped "pocket" at the rear of the three wings (with the roadway at the bottom and the vital corridor-bridge system above) was the site for the new wing. The planning had to provide for the following: (1) efficient corridor connections to the tunnel to the Ross Memorial Pavilion, the bridge to the Montreal Neurological Institute, and to the interns' resi-

dence; (2) corridor connections at many of the floors of the three existing wings, involving problems of varying floor levels; (3) a new passage from the eighth floor of the new wing to the ground floor of the Ross Memorial Pavilion (and thence to the Women's Pavilion), involving a corridor through the empty roof space of the interns' residence, and a bridge; (4) the free passage of the existing roadways beneath the building, combined with new central loading dock facilities; (5) the provision of a direct corridor connection from the existing entrance lobby to the lowest elevator hall of the new wing (a distance of nearly 300 feet, involving open-cut tunneling in the rock beneath the old building and the temporary support of the heavy brick corridor walls above, and their floor loads); (6) special precautions in the planning and control of the extensive blasting required both for the new building and for the tunneling beneath the old building. (All excavation was in solid rock, reaching a maximum depth of cut of 35 feet.); (7) the carrying of the columns supporting the north-east corner of the new building down through the existing power house; and (8) the enlargement and modernization of the existing mechanical and electrical installations without interrupting service.

To carry out this major construction job in the very heart of a busy hospital (especially during the phases when blasting was necessary) required the close daily co-operation of the hospital authorities, the contractor, the architect and the engineers. It is to the contractor's credit that the work was completed without any significant damage, or serious disturbance of hospital routines.

The demolition work required by the project was not extensive, considering the restricted site. The semi-circular end of the east wing was removed, as was a circular stair tower at a corner of the west wing. A relatively temporary structure (housing the animal laboratories) which had been constructed on the roof of the central wing, and extended in the form of a bridge to meet the steep slope behind, was demolished after new laboratories had been completed elsewhere. The enclosed bridges serving as passageways to the Ross Memorial Pavilion tunnel, interns' residence and Montreal Neurological Institute also had to be demolished to clear the site. It was possible to abandon the last of these temporarily and use an existing alternative connection. But traffic carried by the first two could not be interrupted. It was therefore



Entrance foyer to the hospital is modern and spacious. The main entrance leads directly to the new wing.

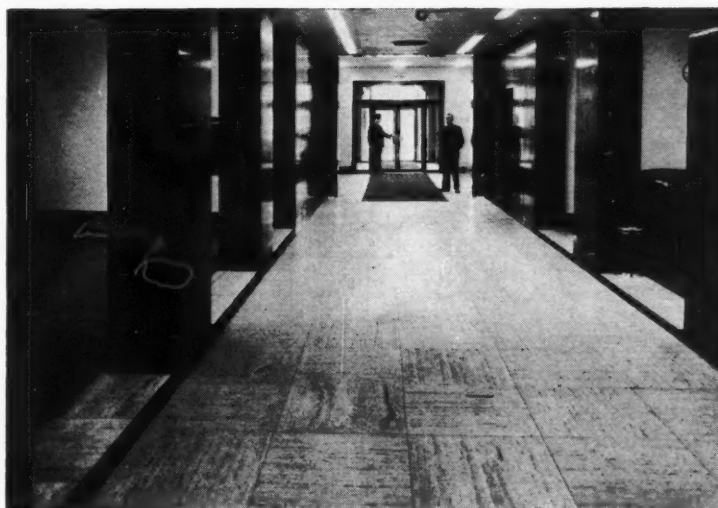
necessary, prior to demolition, to construct temporary substitute passages that would pass through the building under construction, without causing interference, and would be readily adaptable to suit construction progress.

The structural framework of the building is reinforced concrete, which, in this instance, showed a great saving in comparison with fireproofed structural steel. The exterior walls are faced with limestone, and backed with brick. Between the brick and terracotta is an air space, which serves as the only form of insulation for typical walls. For special conditions, e.g. air-conditioned areas, cork insulation and a heavy vapour barrier are provided. Terracotta tile is also used for practically all interior partitions, in virtue of its fireproof qualities, efficiency in reducing sound transmission, and relative economy.

In general, walls and ceilings are plastered. In all corridors, and in rooms where sound absorption is important, suspended acoustical tile ceilings of the perforated asbestos-cement type are used.

The typical wall finish is standard oil paint. Special finishes include the use of the speckled type of sprayed lacquer for washrooms and areas of similar use, wainscots of colour-backed vinyl sheeting in corridors subjected to heavy bed and stretcher traffic, wainscots of glazed ceramic tile to door height in operating rooms and kitchen areas, and marble in elevator lobbies and the main entrance passage.

Linoleum tile is the most widely-used floor finish, occurring in patient rooms, day rooms and all other rooms that do not present special flooring problems. The corridors are finished



The corridor leading from the main entrance to the new wing is nearly 300 feet in length, much of it blasted through solid rock.



Illuminated marble statue of Queen Victoria is located by elevators leading to floors in the new wing.

with all-vinyl tile. Washrooms, bath-rooms, utility rooms, elevator lobbies and similar spaces have terrazzo floors. Kitchen floors are red Welsh quarry tile, set and jointed with special impervious cement. The static-conductive flooring of the operating room areas is a patented terrazzo-like composition, poured and finished in place.

The windows are the counter-balanced type, with both upper and lower sashes reversible for cleaning from the inside. The typical windows consist of aluminum sash and frames, weather-stripped and single-glazed. In air-conditioned areas, and other areas of high relative humidity, the windows are of wood, faced with aluminum on the outside, and double-glazed and weatherstripped.

The flush steel door frames, flush birch doors and the door hardware are characteristic of modern hospital practice. There were special problems, however, such as the extremely heavy lead-lined door of the room where the Cobalt 60 Beam Therapy Unit is housed. The observation windows for this room (and the deep therapy rooms) also involved a great deal of study and the solution of awkward technical problems, which were

solved, in part, and after experimentation, with complex special oil baths, by the use of a well-known medicinal oil to minimize refraction distortion.

High aluminum kickplates for doors and stainless steel corner guards for walls have been used wherever bed, stretcher or truck movement is liable to cause damage. And countersunk aluminum angles for the protection of the hinge edge of open doors have been used judiciously.

Built-in equipment, involving stainless steel, birch, glass, plastic laminates, linoleum, and acid-resisting materials and finishes follow the best modern practice in hospital work. Built-in lockers in the ward rooms are constructed of wood, at a considerably lower cost than the cheapest satisfactory metal units.

The plumbing, heating and fire protection installations are typical of first-class practice. There are no particularly unusual fixtures other than the substantial problems involved in altering and enlarging the existing and active central power house, and tracing, replacing, re-routing and connecting to existing lines. The radiators are convector type, concealed in fully recessed custom-built metal cabinets.

The aluminum window stools are furnished with these cabinets.

As part of the project, a new central incinerator was installed in an addition to the power plant, making use of the main chimney. It is connected by a passageway to the main traffic floor of the new wing which connects to all other units of the hospital group.

Artificial ventilation is provided for all interior rooms that lack natural ventilation, and for all rooms, with or without windows, where special uses call for positive ventilation for the removal of odours, moisture or noxious or dangerous fumes.

Air-conditioning (summer cooling and year-round ventilating and humidity control) is provided for the critical operating room areas and the recovery room. The installation is designed for the maintenance of inside temperatures up to 80 degrees F with relative humidities up to 60 per cent.

Oxygen and vacuum outlets are provided in all ward rooms and are served by central installations. There is also a vacuum system for cleaning purposes.

The electrical services are of course extensive and of many kinds, as they must be in the modern hospital. Only a few items of particular interest will be mentioned.

Lighting fixtures in general are fluorescent, recessed flush with the ceiling wherever possible. The lighting in the wards is handled by the use of a duplex fluorescent fixture mounted on the wall at each bed position. Either up-light for general illumination or down-light for reading, or both, can be had from the single unit. Patients' rooms contain no ceiling lighting. The surgical lights in the operating rooms represent the latest development in this special field. In the event of power failure, they are served immediately, without interruption, by the emergency power generating facilities. Strategically located battery-powered lights go on throughout the hospital in the event of power failure. Lighting is particularly important in the surgical area and staff cafeteria, where there are no windows.

The nurses' call system provides an audible and visible signal as well as inter-communication by voice. A relatively extensive system of inter-communication is provided in the radiology department, to aid in the efficient handling of patients.

Two of the operating rooms have been prepared for the future installation of television equipment, and a system of empty conduits has been installed for eventual transmission to other points in the hospital group, for purposes of instruction.

There is a central radio receiving system, giving a choice of programs to the patient through a small pillow-type speaker. A television antenna has been installed on the roof and it now serves sets located in the day rooms. At some future date, when a suitable small receiving set has been developed for use on the bed table, television could be enjoyed by a patient in a two or four-bed ward without disturbing others. The sound would be carried by the same pillow speaker now used for radio.

From the electrical view-point, the kitchen and cafeteria installations are notable for the extent to which electricity has been used to run the equipment.

The four passenger elevators in a group are of automatic electronic design, synchronized for efficient service. One car, with openings at both sides of the hatchway, is designated primarily for bed and stretcher traffic. The elevators are designed for use with or without operators, and any car may be isolated instantly from synchronization with the others and operated independently to meet a special requirement. There are telephones in the cars. These four elevators and the fifth passenger elevator, at the east end of the building, operate at a speed of 500 feet per minute. The clear inside dimensions of the cars are 5 ft. 4 ins. by 8 ft. 1 in. The sixth elevator is the centrally-located service unit with a speed of 350 feet per minute, and opens into the old central wing as well as into the new wing. There are also two dumb-waiters, one connecting all floors with central sterile supply and the other running between the cafeteria and the kitchen.

A pneumatic tube system, for the transmission of instructions, documents, medicines, specimens, et cetera, serves all floors of the new building. It is part of an ultimate development that will serve and interconnect all of the buildings of the hospital group, and also the Montreal Neurological Institute and the pathology building of McGill University on the east side of University Street. The installation in the central wing has already been made, connecting the new wing to the administration area.

The functional and decorative use of colour throughout the building, and the selection of furniture and fabrics for public spaces and ward rooms, were given a great deal of attention by the architects and hospital authorities. Judging by the general reaction of the public and the staff, the results are notably successful. •

1. 4-bed ward
2. Toilet
3. 1-bed ward
4. 2-bed ward
5. Intern
6. Nurses' station

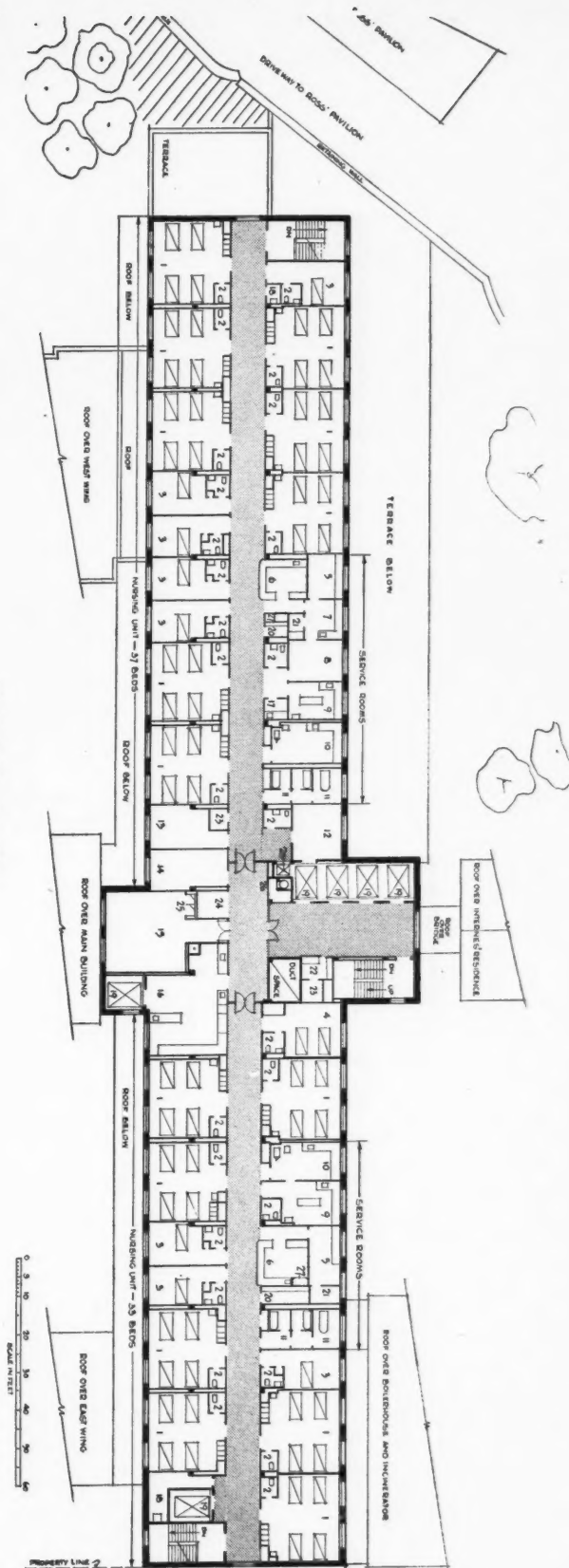
7. Laboratory
8. Consulting
9. Dressing
10. Utility
11. Bathroom
12. Visitors' room

13. Secretary
14. Teaching and conference
15. Day room
16. Serving pantry

17. Flowers
18. Janitor
19. Elevator
20. Linen (clean)
21. Dictaphone
22. Information

23. Storage
24. Stretchers
25. Telephone booth
26. Linen chute
27. Pneumatic tube station
28. Dumb-waiter

Typical Nursing Floor





Nurses' stations, two on each of the four floors for patients in the new wing, feature generous counter and storage space. Interns' work room is located behind.

ON ITS FOUR top floors the new wing of the Royal Victoria Hospital provides space for 274 patients. Each floor contains two nursing units, approximately the same size, in four-bed, two-bed, and single-bed rooms. Patient rooms are painted in soft pastel colours and floors are linoleum tile. On each ward, the location of the service rooms, recreation rooms, nursing station and treatment facilities are the same. This eliminates the confusion so often experienced by students in becoming adjusted when moved from one service area to another.

Layout of Nursing Units

In planning the location of nursing service facilities, thought was given to overcoming long walking distances as well as locating service areas away from patients' rooms. The latter is important because the noise in these areas disturbs the rest and quiet so essential to good patient care.

Grouped together in the centre of the ward are the nursing station, the service rooms (utility room, treatment room, linen room), and the flower room. Behind the nursing station is an interns' work room, laboratory and dictating room.

Centrally located on each patient floor and serving each nursing unit are: waiting room for visitors, a serving pantry, and a patients' dayroom. All the meals are served by the dietary staff and we are assured of attractive, well-planned meals. The dayrooms are bright and gay and greatly enjoyed by the patients. Each dayroom has two telephone booths and a television set. Serving each patient floor is a teaching room equipped with blackboard, a consultation room, and an information office.

Helene M. Lamont, B.N.
Director of Nursing,
Royal Victoria Hospital,
Montreal, P.Q.

In full view of the nurse, and directly across from the nursing station, are two single rooms for very ill or disturbed patients. Allocation of patients to these rooms is decided by the head nurse according to the needs of patients.

Patients' Rooms

The equipment in each room is designed to facilitate nursing care and assure the comfort and privacy of the patient. Each room contains individual lockers with an upper compartment for luggage, a toilet with bedpan flush and sink. Oxygen and suction outlets are available for each bed.

A nurse-patient call system outlet is also located between each bed, permitting patient and nurse to converse with each other at any time — a saving of many needless steps. When the call is completed, the system is re-set at the nursing station, except for the emergency signal in each toilet and each bathroom.

The often distressing noise of bedside radios is now overcome by the provision of radios with under-pillow speakers. As an additional service to patients portable telephones on carts are available on each nursing unit, for use in patients' rooms.

Nursing Station

The nursing stations are compact and practical. The front counter projects into the corridor, enabling the nursing staff to view the whole ward. Ample cupboard and writing space are provided. The nurse-patient communi-

Extended services —

Facilitate Nursing Care

cation panel and pneumatic tube station are conveniently located. Each station contains a small refrigerator and sink for the storage and preparation of medications.

Behind the nursing station is the interns' work room, laboratory, and dictaphone room. This arrangement allows ample work space for the doctors and the nurses.

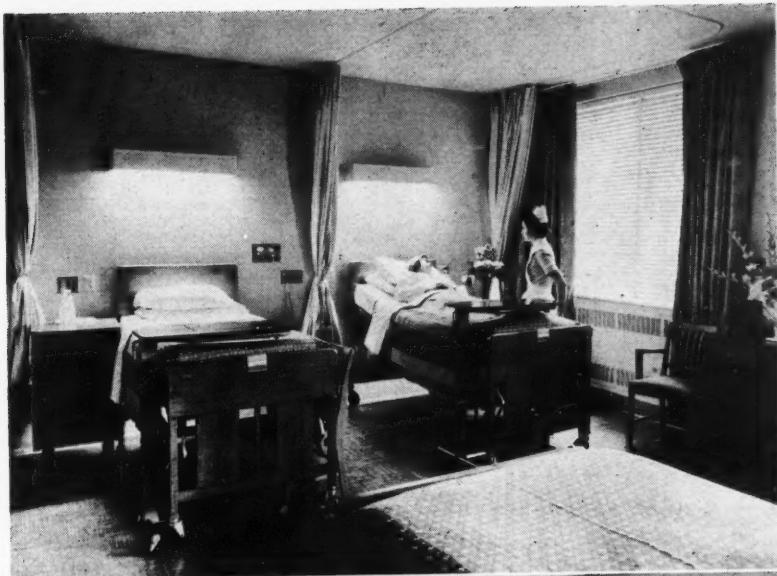
Treatment and Service Facilities

The treatment and utility rooms are located side-by-side. Each utility room is equipped with an autoclave; and the treatment room contains an examining table, x-ray viewing box and generous cupboard and counter space. The linen room is sufficiently large to house the laundry cart which contains the day's supply of linen.

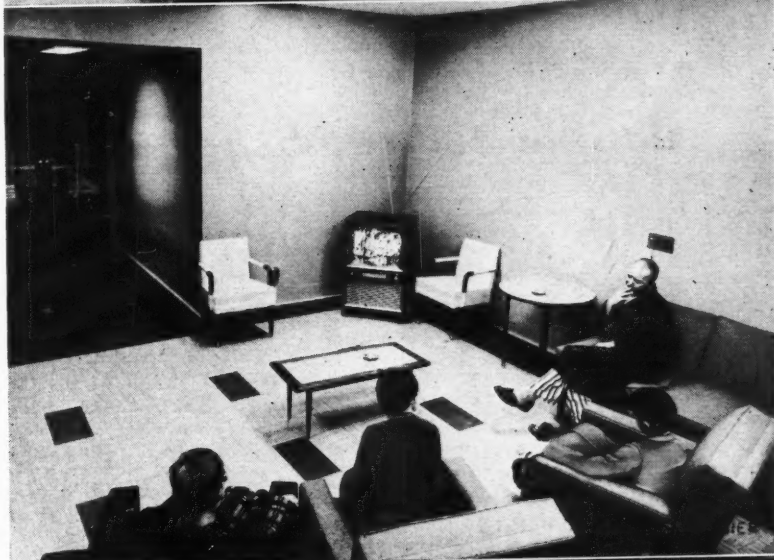
After working a short time in the new wing, it is apparent that the treatment room is a more efficient way of performing examinations and treatments. It also assures privacy for the patient and a better working area for the doctor and the nurse. The clinical teaching of students is much improved.

The comments of the patients, doctors, and nurses are encouraging. Patients are pleased with the quiet of the wards and the soft colours and attractive furnishings in each room. The doctors and nurses know the value in time saved and commend the increased efficiency of the modern service facilities. After a "tradition" born of 60 years of long and open 30-bed wards, the only concern of the nursing staff in the new wing seems to be that they cannot see what each patient is doing at all times. We are not certain that this was ever possible or even necessary. ●

Soft pastel tones, over-bed lighting, and modern decor are features of patients' room in the new wing.



Ambulatory patients relax in day-rooms where television adds to the atmosphere of comfort and relaxation.



Telephones and patient-nurse communication panel are conveniently located in nursing stations, which include small refrigerator and ample drawer space for storage.





The new post-operative recovery room can accommodate 14 patients at one time. Patients are in their own beds, ready for transfer to their rooms.

Extended services —

double-corridor surgery with ancillary divisions

THE FIFTH floor of the new wing contains the operating room suite, the offices of the department of anaesthesia, the recovery room, the surgical pathology laboratory, the offices of the department of surgery, and conference room.

Operating Room Suite

The west half of the floor houses the operating room suite. There are twelve operating rooms, and endoscopy room and a fracture room. This suite is separated from the east half of the floor by doors and the arrangements are such that only authorized personnel, suitably attired to enter an operating room, may enter the area. The dressing rooms for the surgeons, anaesthetists, nurses, nurses' aides and attendants are located in the east half of the floor.

The operating rooms are located along the north and south sides of the suite and are connected by doors with a wide corridor which completely surrounds a central block of rooms and areas. The central block contains the supervisor's station and office, anaesthesia rooms, utility rooms, fracture

* Dr. Webster is Surgeon-in-Chief, Dr. Noble is Anaesthetist-in-Chief, and Miss Warnock is Operating Room Supervisor.

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O.B.E., M.D., C.M., M.Sc.,
Ph.D., F.A.C.S., F.R.C.S. (C)
and
Alan B. Noble, M.D., F.A.C.A.,
and
Mary Warnock, R.N.
Royal Victoria Hospital,
Montreal, P.Q.

room, sterile storage and instrument storage rooms. Doors at each side of these rooms connect the north and south sides. The suite is air-conditioned and a steady, comfortable temperature is maintained. Fluorescent lighting is used throughout.

Supervisor's Station. This is a crescent-shaped open counter area into which come all the emergency calls from the various operating theatres. In this area are the safety control panel, for the ventilation of the entire suite, and the control panel for the nitrous oxide bank. A pneumatic tube system facilitates sending and receiving messages to and from other departments of the hospital.

Operating Room. The accompanying plan clearly shows positions of the scrub room and sub-utility room which link each pair of operating rooms. Two

operating rooms are provided with a glassed-in observation gallery and equipped for the installation of cinematographic and television camera equipment. They are also fitted with electrical conduits for special monitoring apparatus which can be placed in the observation gallery.

Each operating room is approximately 20 by 20 feet, with a ceiling height of approximately nine feet. There are three doors: one wide door opening into the corridor, one opening into the scrub room, and one opening into the adjacent sub-utility room. There is an illuminating screen for x-ray films on one wall; at the end occupied by the anaesthetist there are wall conduits for piped oxygen and nitrous oxide, suction, and an emergency call switch. Another suction inlet and an emergency call switch for the nurses' use are on the opposite wall. Each room has a large easily manipulated overhead light which, in the event of a power failure, automatically switches over to diesel power. Three of the operating rooms (endoscopy, fracture and x-ray) have compressed air, necessary for the operation of pneumatic instruments. Built into the wall next to the corridor there is a cupboard for the storage of commonly-used solutions, suture material and other items. There are no outside windows in any of the operating rooms so that the full advantage of artificial illumination may be taken.

The large fracture room is located in the central block; adjacent is a dark room for the processing of x-ray films. The endoscopy room is large and is completely equipped.

Permanently installed radiologic equipment is present in one operating room and portable equipment is avail-

able in this and other operating rooms. The bone bank deep-freeze unit is located in one of the storage rooms and there is a refrigerator for the temporary storage of transfusion blood near one end of the operating room suite.

Anaesthesia Room. There are six anaesthesia rooms, so located that each room services two operating theatres. Each room is provided with a sliding screen on the doorway to ensure quiet and privacy. The equipment consists of a small wall suction unit, piped nitrous oxide and oxygen, and a mobile stainless steel table and stool. A metal cupboard is built in the wall. The upper section has glass doors and contains a complete set of laryngoscopes, connections and endotracheal tubes. The lower section has solid doors for storage of trays for spinal, epidural and regional anaesthesia. There is also an emergency call switch in each room, connected with the office of the anaesthetist-in-chief.

Patients are transferred from bed to operating table in the anaesthesia room. Anaesthesia is commenced before transporting the patient to the operating room. Systematic use of these rooms, in addition to rendering the patient less apprehensive, materially decreases the delay between operations. An adequate number of anaesthetists makes it possible to start anaesthesia while the previous operation is being finished.

Utility Room. This is located in the central block and is used for the general cleansing of instruments and equipment.

Storage Rooms. These are also in the central block. All-metal cabinets are used for the storage of instruments, linen, solutions and other supplies.

Transportation of Patients. One elevator, manned by an operator, is used for the transportation of patients in their beds to and from the operating room suite. One door opens directly into one end of the suite, the other opens into the elevator lobby.

Supplies Elevator. There is a "dumb-waiter" type of elevator which is used for the transportation of supplies to and from the central supply room which is located on the second floor.

Communication System. The operating room supervisor has, at her station, an "inter-com" device by means of which she can speak directly with anyone in the dressing rooms, anaesthetist's office, the office of the surgeon-in-chief, the recovery room, and the conference room.

Explosion Hazard. All electrical connections and switches are explosion-

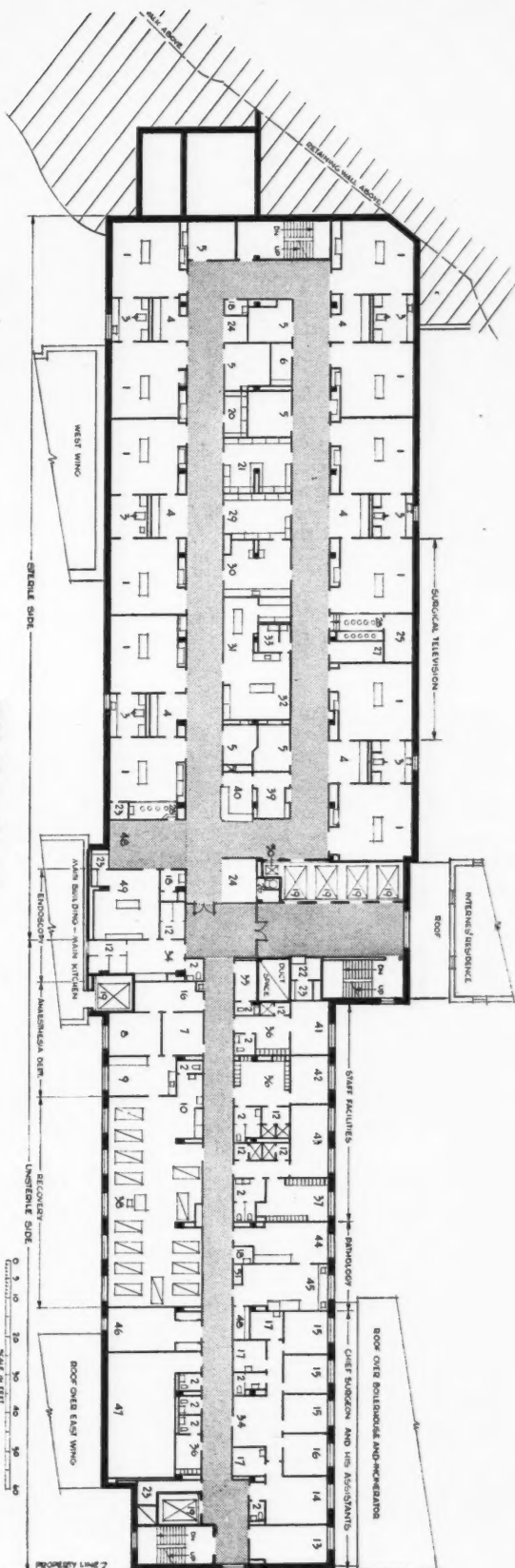
1. Operating room
2. Toilet
3. Sub-sterilizing
4. Scrub-up
5. Anaesthesia room
6. Anaesthesia store
7. Anaesthetist's office
8. Anaesthetist-in-chief
9. Anaesthesia work room
10. Sub-utility room

11. Shower
12. Dressing
13. Coffee bar
14. Surgeon-in-chief
15. Assistant surgeon
16. Secretary
17. Examining
18. Janitor
19. Elevator
20. Linen (clean)
21. Sterile storage

- Fifth Floor: Surgery**
22. Information
 23. Store
 24. Stretchers
 25. Television control
 26. Linen chute
 27. Drugs & solutions
 28. Observation gallery
 29. Instrument room
 30. Clean up
 31. Cast room
 32. Fracture room

33. Dark room
34. Waiting room
35. Orderlies
36. Lockers
37. Doctors' lockers
38. Recovery room
39. Office
40. Supervisor
41. Nurses' lounge
42. Interns' lounge
43. Doctors' lounge

44. Pathology secretary & microscopes
45. Pathology laboratory
46. Operating dept. secretary
47. Pathology seminar room
48. Bed bay
49. Endoscopy
50. Dumb-waiter
51. Pneumatic tube station



proof. The floors of the operating room suite are conductive. All personnel must wear cotton uniforms as well as conductive apparatus on the heels of their shoes. Personnel are required to test the efficiency of their conductive attire by means of one of two conductometers permanently installed in the suite. Every precaution is taken to prevent explosions of anaesthetic gases due to discharge of static electricity or ignition by hot cauteries and "sparks" from electric connections.

Attire of Personnel. Precautions are taken to keep bacterial contamination in the suite to a minimum. These include the requirement that all personnel wear freshly laundered cotton uniforms, shoe covers and hair covers while they are in the suite. No one, with the exception of patients, may enter the operating rooms without a face mask in proper position. Special postoperative disposal of contaminated clothing and materials is carefully observed.

Nursing Staff. This is composed of the operating room supervisor, clinical

instructress, staff nurses, postgraduate students and undergraduate student nurses. Specially trained operating room nurses supervise in each individual room.

Attendants and Aides. There are male attendants who carry out the or-

ders of the nurses-in-charge and transport the patients. Female aids cleanse equipment and perform other duties.

Related Facilities

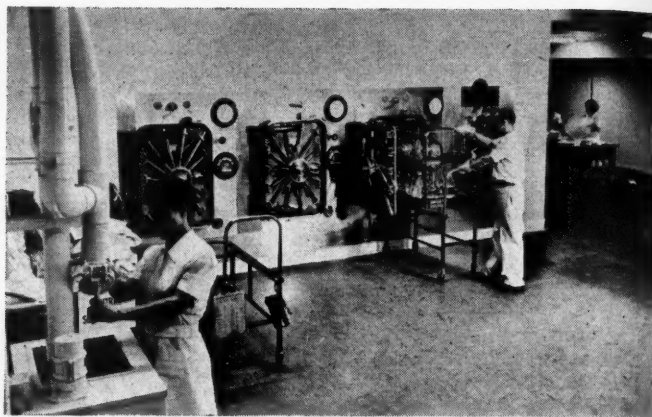
Anaesthesia Offices — These are adjacent to the operating room suite on the one side and to the recovery room on the other. They include the office of the anaesthetist-in-chief, the office of the departmental secretary, a conference room and a utility room. In the utility room are kept special pieces of equipment with extra supplies and here the departmental nurse cleanses equipment and prepares the various "sets" of apparatus for sterilization. The staff anaesthetists are assisted by postgraduate and undergraduate students.

Recovery Room. The patient, after the operative procedure has been completed, is transferred to his bed and then transported on it to the recovery room where he remains until fully conscious, before being returned to his room. A staff of nurses cares for the patients and resuscitative measures are carried out or supervised by the anaesthetists, with the aid of the surgical staff when necessary. The postoperative orders are written in the recovery room by the assistant surgeon and accompany the patient to the surgical floor when he leaves.

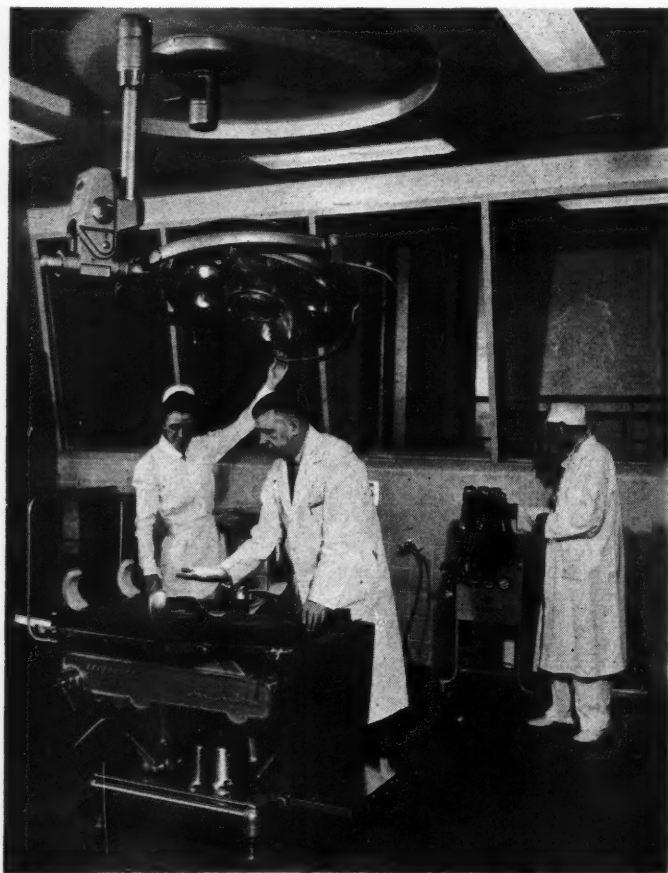
Staff Dressing Rooms. There are five dressing rooms for the operating room staff, each containing lockers, lavatories, showers, and a sitting room.

Surgical Pathology Laboratory. This consists of two rooms where surgical specimens are received, examined, described, and then stored for a few days in a cold cabinet. Pathologists are present throughout the day to do this work and to be available for making frozen section diagnoses when requested. One paraffin section is al-

(Concluded on page 94)



The new central sterile supply, which serves the operating rooms and other areas of the hospital.



Shown in one of the new operating theatres are the authors, left to right: Dr. Donald R. Webster, Mary Warnock, and Dr. Alan B. Noble. This room is equipped with a viewing gallery.

THE FOCAL point in the planning of a department of radiology for any hospital, but especially for a large teaching institution such as the Royal Victoria Hospital, must be the patient. All activities of the department are concerned primarily with the patient — his proper examination or treatment, the records or other reports of such services for advice of the attending physicians, and the maximum practicable comfort for the patient when having such examination or treatment.

Thorough study is therefore imperative: facilities for all types of examinations or treatments which may have to be accomplished; the means or mode of access for hospitalized and ambulatory patients to the department; the relative clinical load; the teaching and research facilities; accommodations for the technical, clerical and attendant personnel; storage of the daily supplies; the protection of departmental personnel from any unnecessary radiation hazard; and the working and consulting areas for the radiologists, resident staff, and undergraduate medical students.

The floor plan evolved for the Royal Victoria Hospital was based on: previous experience; a detailed study of present needs as indicated; the current and anticipated future bed capacity; together with some attempt at clairvoyance in anticipation of the probable changing pattern of medicine and medical practice as it might affect this hospital and the department over the next 10 to 25 years.

Using the central position of the bank of elevators as a point of reception or arrival of the patient (and as a means of access for members of the resident and attending staffs of the hospital), the department has been arranged to extend to both left and right in a functional manner. This permits a central control of patient movement by the reception-and-appointment secretary, the nurse supervisor and the chief technician. From this control desk the patient is readily directed or transported to the registrar; and thence to a waiting room or directly to an examining area or treatment section without delay. The 84-foot width of the western half of the floor area, permitted by the general terrain, enabled the use to the west of a central-core pattern which accommodates certain operating, control, and waiting rooms along the main or south corridor. Personnel locker and dressing rooms, with showers and lavatories, are along the north corridor.

* Dr. Peirce is also chairman of the hospital's medical board.

Centralized

Radiology

Department

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Radiologist-in-Chief,
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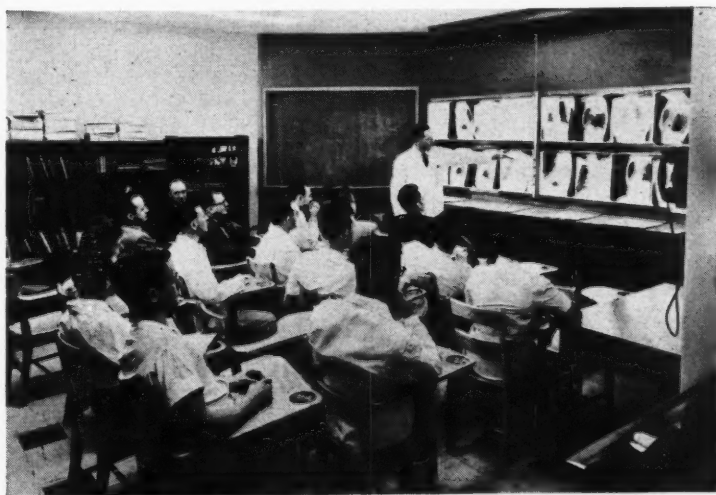
The fluoroscopic rooms and a special examination room, particularly for accident cases or head injuries, are concentrated near the entrance to the department — readily accessible for either walking patients or for the wheel chairs, stretchers or beds of hospitalized cases. It is noted here that walls throughout the department of radiology are protected against vehicular damage with vinyl sheeting.

Diagnostic Radiology

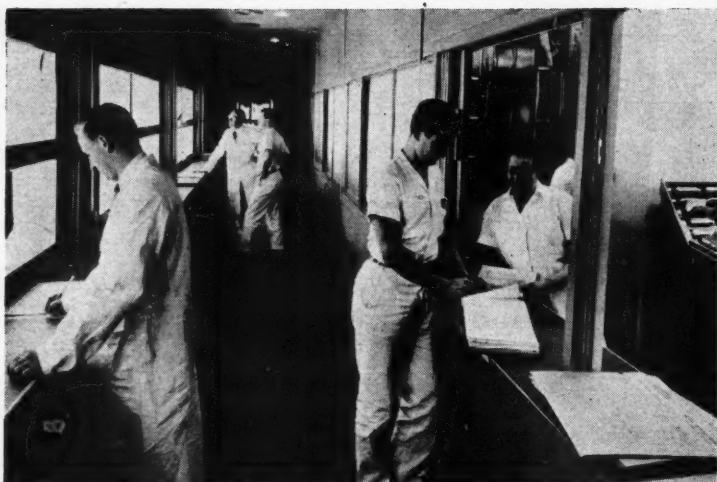
With the exception of the radiographic room which has just been mentioned as especially fitted for examinations of the skull, sinuses or mastoids, foreign bodies in the eye, or urgent accident cases, the diagnostic operating or radiographic-fluoroscopic rooms are arranged in four suites. Two of these suites are for radiography only, two for fluoroscopy and radiography. Each suite is composed of a utility

room connecting the two relatively matched operating rooms, each of which has an adjoining group of dressing cubicles, together with a "recovery room" fitted with a couch for specially ill patients. Each group of dressing cubicles has a toilet and lavatory for the convenience of the patients. These, together with recesses and bays off the main corridor for wheel chairs, beds and stretchers, afford the patients a maximum of comfort while preparing or waiting for their examinations.

One radiographic suite, a major dark room, a public patients' waiting room, a dental radiographic room (which has its own dark room) and half of one of the fluoroscopic-radiographic suites are arranged to the left of the entrance to the department. The remaining portion of the first fluoroscopic-radiographic suite, a major radiographic suite, and the fluoroscopic-radiographic suite for private patients, together with another major dark room, were planned in the western portion of the diagnostic section to the right of the entrance, along with the special radiographic room.



The seminar room, which accommodates 32 persons, is used for teaching and conferences.



The "long gallery", or staff film-viewing room in the radiology department, is equipped with 64 film illuminators. Adjoining is the diagnostic records office.

In the several radiographic and fluoroscopic-radiographic rooms the controls for the technicians are protected with floor to ceiling plate glass panels affording a full view of the patient. Each of these control bays is fitted with its own stainless steel sink and work cabinets. Linen and accessory storage cupboards have been built into each room for the convenience of the technician in taking care of the individual patient. Utility rooms are equipped with bedpan washers, sterilizers, racks, sinks, as required.

Overhead or ceiling-mounted tube carriages have been used in six of the nine diagnostic operating rooms, thus clearing the floor areas for movement

of personnel, beds, stretchers and other apparatus. To facilitate the care of the patients, each operating room has adjacent to it a film changing room in which the technicians effect photographic identification and labelling of films on each patient, and by means of which they may control their cassettes and the proper supply of films at all times.

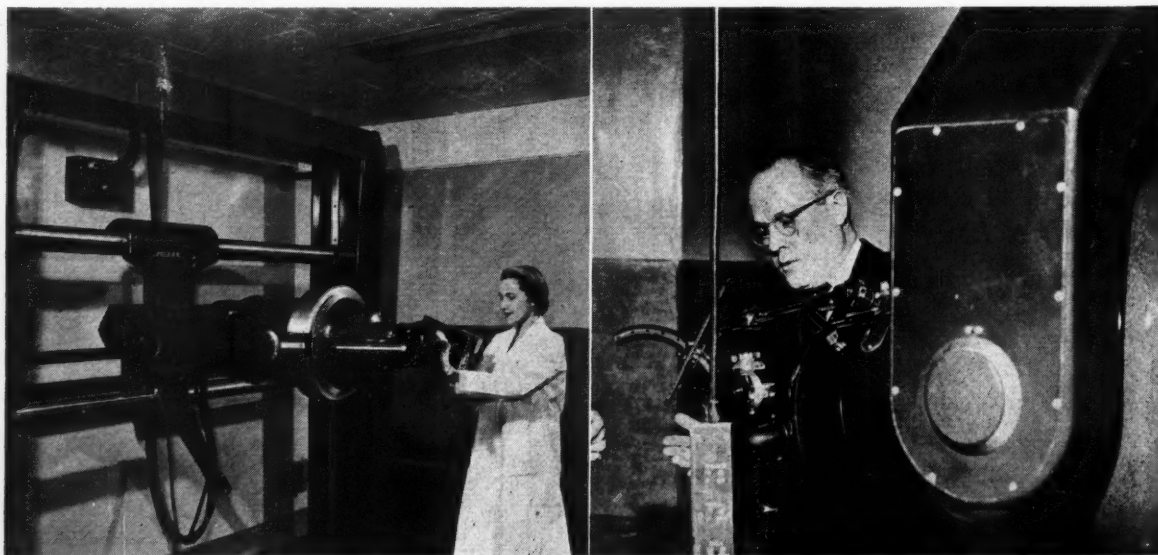
Two major dark rooms service the exposing rooms. Each of these, because of the fact that blind people are employed for the processing of films, consists of two parts. The light-proofed part for the developing and fixing of the radiographs is fitted with special arrangements for the

blind personnel to handle their film hangers and time the processing.

Special electrically-controlled mixing valves keep the processing baths and wash water at a constant temperature. Once the blind technician places the films in the wash water they are pushed through into the other part of the dark room by means of the common tank which passes through the wall. In these outer dark-rooms the wet films then may be inspected in order to check on the technique or to give rush verbal reports before the roentgenographs can be partially drip-dried or finished in chemical anhydrators. The special examination room has its own dark room in order to facilitate the technical handling of accident or other special cases. This area, as has been pointed out, is immediately contiguous to one of the bank of four elevators particularly designated to carry surgical or x-ray patients. Its doors open either directly into the department when required or on to the main foyer.

On the surgical floor, one of the major surgical theatres has been equipped with an overhead roentgenographic tube carriage (on which has been suspended also an operating light) controlled from the observation gallery for that theatre. A heavy duty, x-ray generator is installed in the gallery to energize the overhead, shock-proof, rotating anode tube. A heavy duty mobile x-ray unit, capable of developing 100 ma. and a fully equipped dark room off the neighbouring "fracture and plaster" room complete the

(Concluded on page 90)



Left: a diagnostic room in the new x-ray department. Right: Dr. Carleton Peirce is shown here explaining the Cobalt 60 Beam Therapy Unit.

1. Conference & seminar room
2. Dark room
3. Clinical research
4. Rad. physics laboratory
5. Radiation physicist
6. Clin. asst. resident
7. Asst. rad. therapy.
8. Radiologist i/c therapy
9. Toilet
10. Examining
11. Radiologist-in-chief
12. Secretaries
13. Clerks

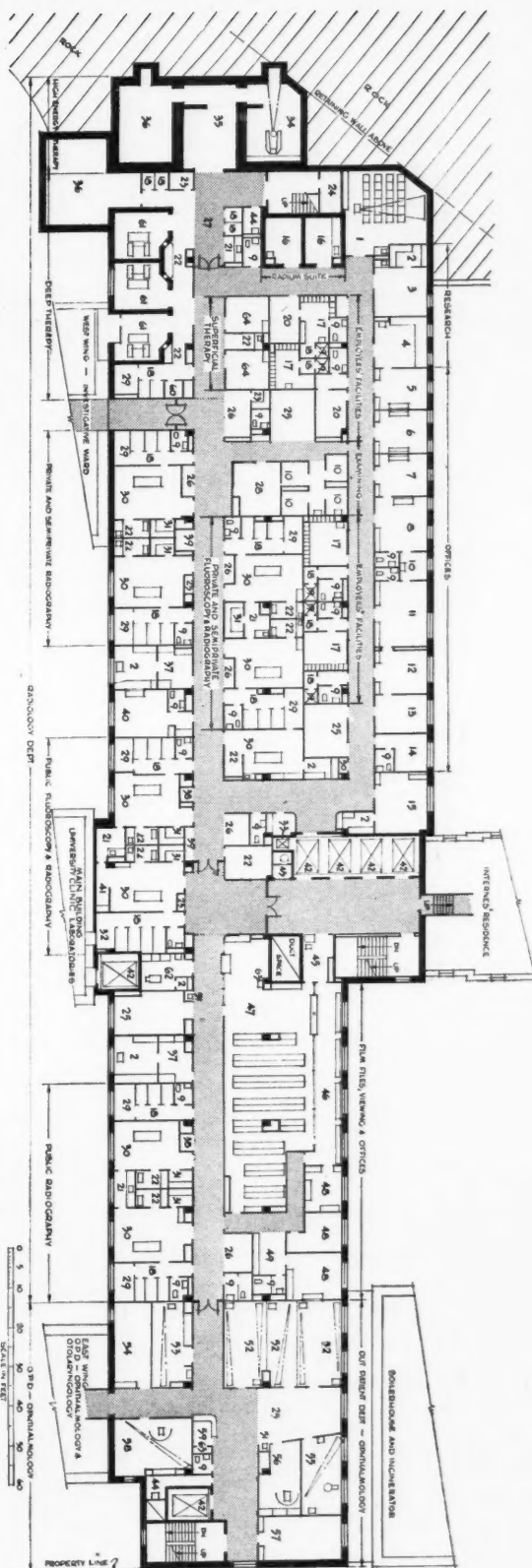
14. Chief technician
15. Micro recorder & film proc.
16. Radium therapy
17. Locker room
18. Dressing
19. Shower
20. Rest room
21. Utility
22. Control
23. Linen (clean)
24. Storage
25. Waiting room
26. Stretchers

27. Lobby
28. Secretaries & records
29. Recovery
30. Radiology diagnostic
31. Film loading
32. Passage
33. Dumb-waiter
34. Cobalt unit
35. Control Foyer
36. High energy therapy (future)
37. Wet film viewing
38. Wheel chairs

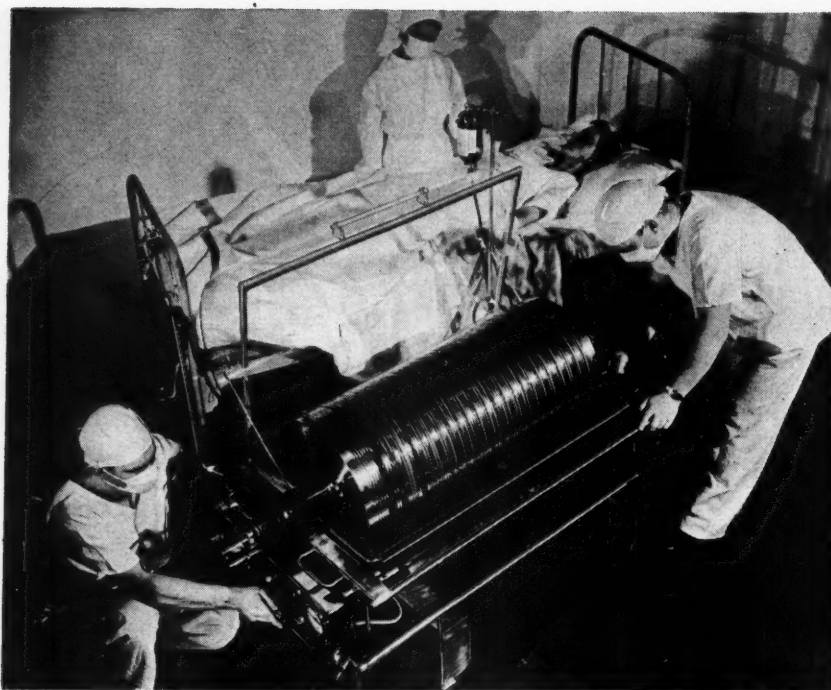
39. Ushers
40. Radiologist i/c diagnosis
41. Reporting
42. Elevator
43. Linen chute
44. Janitor
45. Information
46. Film viewing
47. Active film files
48. Dr.'s office
49. Interns' work room
50. Stationery
51. Drinking fountain

52. Refraction room
53. Consultation room
54. Camera room
55. Treatment room
56. Perimetry
57. Staff conference room
58. Orthoptics
59. Appointment
60. Closet
61. Deep therapy
62. Dental
63. Pneumatic tube st.
64. Superficial therapy

Fourth Floor: Radiology



All plans contributed by the architects: Barott, Marshall, Montgomery, Merrett, Montreal.



Located in the urology department is the hospital's specially constructed artificial kidney, used in the treatment of anuria.

Extended services —

featuring a complete urology unit

THE department of urology is situated in the western half of the sixth floor of the new wing of the Royal Victoria Hospital. It has accommodation for forty patients, employing, as in other parts of the new wing, the multiple occupancy plan.

It is felt that there are few if any urological services on the continent that have a more complete or more efficient type of establishment. It was planned to combine good nursing care with comfortable surroundings for patients, to allow for efficient urological investigation and treatment, for teaching, clinical investigation, and research.

In addition to the nine 4-bed rooms the department has one 2-bed room and two single rooms. The latter are considered as sick patient or isolation units. A comfortable lounge room with television is available for the use of ambulatory patients. This is a very popular feature with patients and undoubtedly helps to keep up their morale during a worrisome period.

Four adjoining cystoscopy rooms form the hub of the professional area, which is separated from the patient

**Allan B. Hawthorne, M.D., C.M.,
F.A.C.S.**

**Urologist-in-Chief,
Royal Victoria Hospital,
Montreal, P.Q.**

area by a doorway. In addition to intravenous urography and cystoscopic investigation, all endoscopic surgery is performed in these rooms. The proximity of the patient area permits minimal transportation and allows careful and frequent observation of the post operative patient. The cystoscopy rooms are provided with all modern anaesthesia and x-ray facilities. A large volume of endoscopic work can be done quickly and efficiently.

A seminar or teaching room is located in the same area. It is used for undergraduate teaching of medical students and for departmental ward rounds and meetings. Projection equipment has been provided and excellent wall space is available. These features are of great assistance in the visual education which is utilized to a considerable extent.

The department has both clinical and research laboratory rooms. Ad-

joining the former is an interns' work room where the patients' chemical charts are kept. The room is provided with x-ray viewing boxes for the reporting of pyelograms.

The activity of the research laboratory is at the present time chiefly related to investigation into the causes of calculus formation. Equipment in this room includes an artificial kidney which is used periodically in the treatment of anuria.

Also provided in the professional area are attending staff and secretarial offices. The unit is compact and complete. With a minimum of effort, the increasing work of the department can be conducted with maximum efficiency.

Artificial Kidney

The Royal Victoria Hospital's artificial kidney, shown in the illustration, is an 800-pound apparatus which stands ready at all times to aid patients whose lives are threatened by acute renal failure.

The world's first artificial kidney was developed by Dr. W. J. Kolff in the "underground" in Holland during

World War II and the first patients treated with the apparatus were German prisoners of war who were suffering from acute renal failure. After the war, Dr. Kolff offered Dr. Calvin Miller, then surgeon-in-chief at the Royal Victoria, a complete unit, ready for use, with the request that Dr. Miller take one of Dr. Kolff's students for further training. The student chosen was Dr. K. N. M. de Leeuw who has since become an assistant resident in the hospital's department of medicine.

When the kidney was received from Holland, it was taken over by the department of urology. A team was formed consisting of one member from each of the departments of medicine, surgery, haematology, and urology. Funds to carry on the required work were provided by grants from McGill University and other sources.

The artificial kidney now in use is a modification of the original model. It is constructed entirely of stainless steel and, being custom built, is priced at more than \$6,000.

This apparatus is used primarily in treatment of conditions where the renal function is temporarily suspended and a condition of uraemia results. In certain cases it may become necessary to remove from the blood some of the toxic products of the uraemic state. This permits survival of the patient and, with return of the renal function, allows for complete recovery.

The steel kidney applies the principles of dialysis. The patient's blood is shunted through a tubing which is wrapped around a receiving drum and immersed in a bath solution. By varying the constituents of the solution, it is possible to remove certain toxic constituents of the blood and retain others. The blood is shunted through the patient's radial artery and returns through the saphenous vein. Because of the many laboratory examinations that are necessary, the departments of haematology and biochemistry make an important contribution to this work.

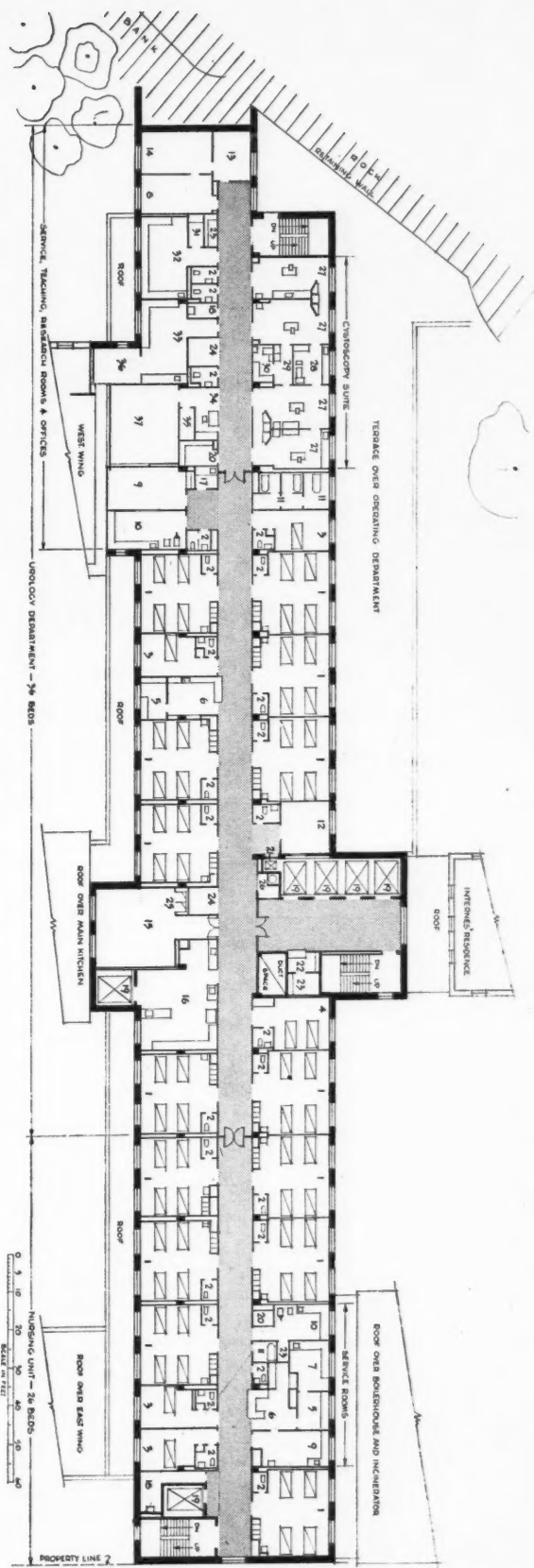
It is anticipated that the artificial kidney may soon be used in the treatment of varying types of poisoning. Then, too, the department of medicine expects to form a renal investigative unit in the near future. Since the artificial kidney will play an integral part in the functioning of this unit, it will thus become of investigative as well as therapeutic importance.

Our profession is the only one which works unceasingly to annihilate itself.
— M. H. Fischer, M.D.

1. 4-bed ward
2. Toilet
3. 1-bed ward
4. 2-bed ward
5. Intern
6. Nurses' station
7. Laboratory
8. Consulting
9. Dressing
10. Utility
11. Bathroom
12. Visitors' room
13. Secretary
14. Urologist-in-chief
15. Day room

- Sixth Floor, West Wing: Urology**
16. Serving pantry
 17. Flowers
 18. Janitor
 19. Elevator
 20. Linen (clean)
 21. Dumb-waiter
 22. Information

23. Storage
24. Stretchers
25. Telephone booth
26. Linen chute
27. Cystoscopy & pyelography
28. Sterilizing
29. Wet film viewing & drying
30. Dark room
31. Balance room
32. Research laboratory
33. Routine laboratory
34. Cystoscopy supervisor
35. Chart & film storage
36. Interns x-ray viewing
37. Seminar room





The new staff cafeteria, seating 476 persons. Serving counter is located behind the glass divider, seen in the background.

Extended services —

decentralized dietary service

FOR MANY years the Royal Victoria Hospital's dietary department has been meeting increased demands in food service, both in numbers and changing standards, with relatively minor renovations or additions to equipment. It became imperative that complete new facilities be included in the hospital's building program. To date, a new main kitchen, four ward pantries and a staff cafeteria have been opened, with a new bakeshop to be completed in a few months' time.

Objectives

Several objectives were established in planning the new department and were kept uppermost in mind throughout the planning stage. These were:

1. The observance of a "straight line flow of work" as a basic principle. In this hospital, where the food service is decentralized and patient units not confined to one building, it is necessary to have the food leaving the kitchen from two points at opposite ends. Despite this potential problem, there were few deviations from this principle.

2. Provision of adequate cooking equipment to eliminate the need for holding cooked foods for lengthy periods to meet peak loads.

3. The provision of adequate refrigeration.

*Miss Sortome is Director of Dietetics and Miss Wynne is the Assistant Director of Dietetics. The abbreviation "P.Dt." stands for professional dietitian. (See page 64).

Eleanor Sortome*, B.H.Ec., P.Dt.,
and
Gladys Wynne, B.Sc., P.Dt.,
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4. Use of mechanized equipment, where practical and desirable, to reduce labour costs.

5. In designing equipment, primary consideration (apart from the functional aspect) to be given to sanitary features and ease of cleaning.

6. The surroundings, both in work areas and dining areas, to be made as attractive as possible.

Main Kitchen

Since the kitchen is the heart of any dietary operation let us review the highlights there first (fifth floor building No. 1, block plan page 37). Floor space is sufficient to allow a breakdown into work areas and provides excellent aisle space. The floor is red quarry tile and the walls, to a height of seven feet, are yellow

glazed tile. Above this the plaster is painted silver grey and the acoustic ceiling yellow. The ceiling in the central area is raised with a centre skylight. All this, in addition to many windows and complete air-conditioning, contributes to an immediate appearance of brightness and spaciousness as one enters the kitchen. All fabricated equipment is made of stainless steel.

Food and other supplies are transported to the kitchen on an elevator, assigned exclusively to the dietary department. Since we are required to hold only daily food supplies, refrigeration and stores area are sized accordingly. There are four walk-in refrigerators, three opening from the centre aisle and one opening into the utility room for garbage. All are built flush with the outside floor level and have stainless steel doors. Inside walls are tiled and thermometers on the outside wall register the inside temperature.

The vegetable preparation area is enclosed with a five-foot wall. Two 33-lb. potato peelers are adequate for the volume of peeling. One brush was specified to be interchangeable with the abrasive disc in the bottom of the peeler for scrubbing potatoes for baking. This has proved most successful. Sinks are located to permit working on both sides. One vegetable cutter and chopper handles all of the preparation for cooking and salads. The salad work area is adjacent. All salad ingredients are prepared here in bulk and held either in pass-through refrigerators opening into the aisle, to be picked up for the ward pantries, or on salad trucks in two wheel-in refrigerators for the cafeteria.

Food Service

sponsored by the

Canadian Dietetic Association

The cooking equipment, all electric, is confined in the wide central area of the kitchen. Because prepared food must leave the kitchen from two ends, a wide centre aisle was regarded as necessary and served to divide this area into two sections — range- and over-cooking, and steam cooking.

Equipment in the steam cooking area which is adjacent to the vegetable preparation area, includes: three 3-compartment steamers; two 100-gallon and two 80-gallon, one 40-gallon and four 30-gallon kettles; and one 50-gallon steam jacketed coffee urn. The food conveyors are loaded directly from the kettles or, if the items must be handled after cooking (e.g., mashed potatoes), from a heated serv-

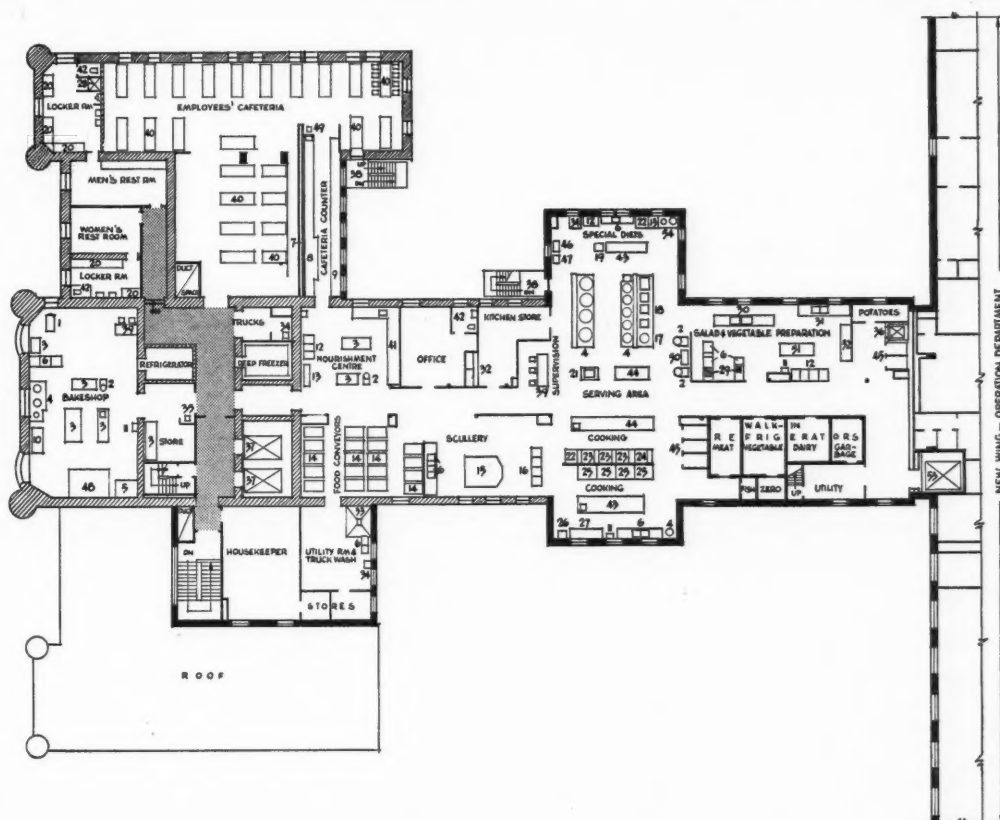
ice table. Although it was hoped to eliminate a special diet kitchen, the number of special diets we are called upon to prepare made it essential to have a separate unit to handle this preparation and it is located in this area. All salt-free and special items for diabetic, low-fat, and other diets are prepared here.

Cooking equipment consists of two 28-lb. deep fat fryers, three ranges with all-purpose tops, and one double broiler. Four 2-deck roast ovens meet requirements and leave space for the addition of another piece of equipment should future needs demand it. Completing the equipment in this area are: a table with underneath bins for flour, bread crumbs, and salt; a double compartment sink with drainboards for

soaking fowl and fish; and a work table 16 feet long and 4 feet wide. Heated units have been built into the long service table adjacent to the centre aisle. Three wheel-in refrigerators hold trucks, one designed for leftovers and the others for trays of bacon, meat patties and other items prepared in advance for cooking.

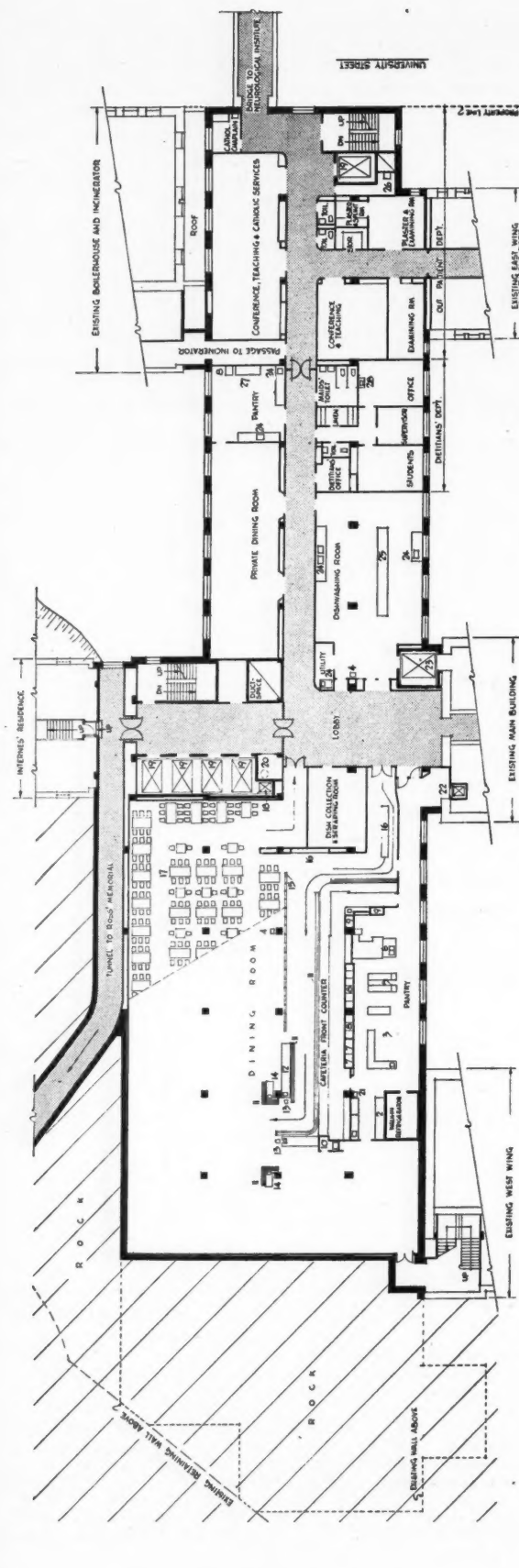
At one side of the main kitchen and in the centre of this cooking area, a control desk allows continuous supervision by the dietitian and chef. All telephone orders are received here and an inter-communication station on this desk has speaker outlets in the various kitchen areas.

One of the greatest joys in the kitchen is a mechanical pot and pan washer. In addition to the cooking



Main Kitchen, Fifth Floor, Main Building

- | | | | |
|---------------------------|-----------------------------------|--------------------------------|--|
| 1. Freezer | 15. Pot and pan washer | 29. Peeler | 43. Cook's table |
| 2. Mixer | 16. Pass thro' clean dish storage | 30. Vegetable preparation sink | 44. Service table |
| 3. Work table | 17. Coffee urn | 31. Salad preparation sink | 45. Walk-in refrigerators |
| 4. Kettles | 18. Steamers | 32. Linen cupboard | 46. Utility table |
| 5. El. oven | 19. Scale | 33. Floor drain | 47. Seasoning table |
| 6. Sink | 20. Lockers | 34. Slop sink | 48. Revolving tray oven |
| 7. Tray rail | 21. Bain marie | 35. Water cooler | 49. Cashier |
| 8. Cafeteria frontcounter | 22. Broiler | 36. Dumb-waiter to cafeteria | 50. Mixer table |
| 9. Back bar | 23. Range | 37. Elevator (passenger) | 51. Salad table |
| 10. Proofer | 24. Fryers | 38. Fire escape | 52. Vegetable table |
| 11. Hand sink | 25. Combined ovens | 39. Dietitians' desk | 53. Elevator to general stores, snackbar and dishwashing below and ward pantries above |
| 12. Reach-in refrigerator | 26. Food cutter | 40. Dining table with chairs | 54. Tilting table kettles |
| 13. Cupboard | 27. Cabinet table | 41. Work counter | |
| 14. Trucks | 28. Shower | 42. Toilet | |



Cafeteria, Third Floor, New Wing

1. Beverage section
2. Ice cream
3. Dessert preparation
4. Water cooler
5. Salad preparation

6. Breakfast preparation
7. Warmers
8. Refrigerators
9. Pass thru' thermotainer
10. Cleaners' closet

11. Tray rail
12. Counter
13. Cashier
14. Counter with water cooler
15. Glass screen

16. Trays
17. Dining table with chairs
18. Dumb-waiter
19. Elevator
20. Linen chute

21. Hand sink
22. Dumb-waiter to main kitchen
23. Elevator to main kitchen and wards above and kitchen storages below

24. Sink
25. Dishwashing machine
26. Janitor
27. Work counter
28. Pneumatic tube station

equipment, all service pans from the ward pantries and the cafeteria are washed here. Two men working on shifts are able to handle the large volume of washing entailed — a decided labour saver. Clean pans go into a pass-through storage cupboard or onto a movable rack for transportation to specific areas.

Food conveyors are stored and heated in the area beyond the pot-washing. Opening off this area will be a utility room and truck-washing area but at present the space is being utilized temporarily as a bakeshop. In the kitchen a centre has been equipped for the preparation of milk shakes, tube feedings and other supplements.

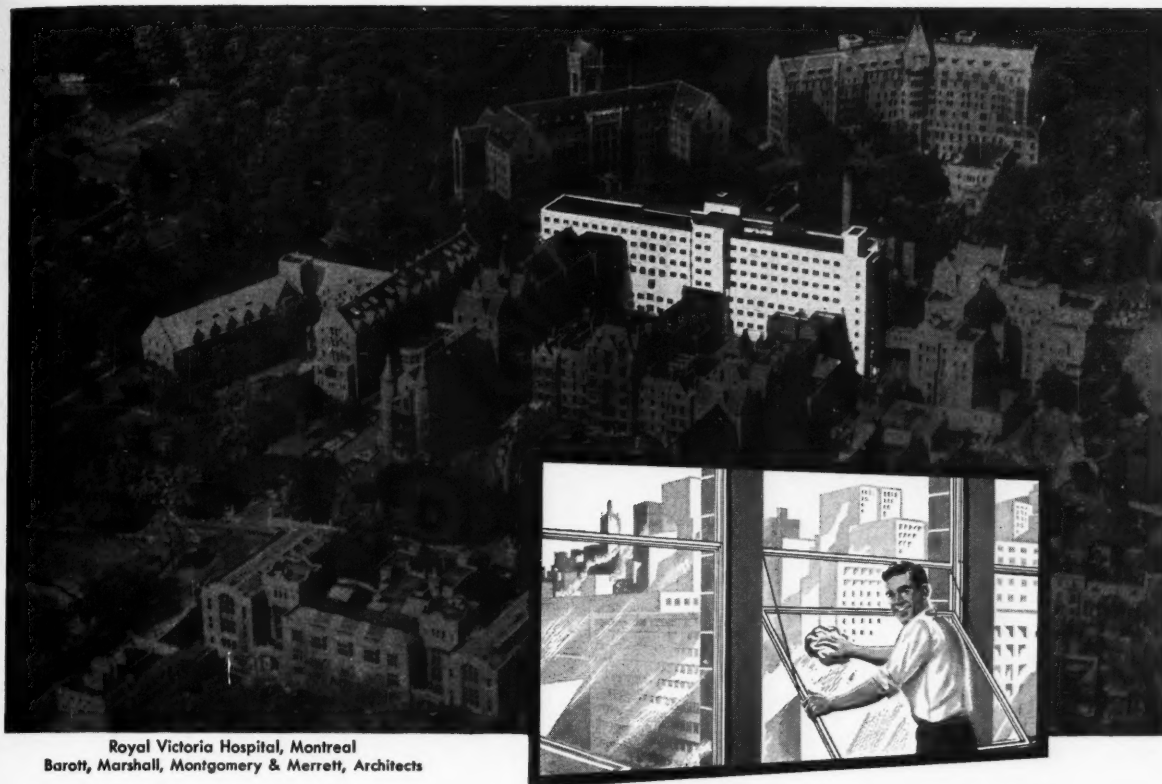
Floor Pantries

Patient food service in the new wing is decentralized, with one pantry on each floor equipped to serve trays for approximately seventy patients. Bulk food conveyors, one for each floor, carry the food from the main kitchen (fifth floor building No. 1), and since the dietary elevator opens directly into each of the pantries, the service is very direct. All patients are given a selective menu from which to choose their meal. The trays are partially set up when the food conveyor arrives and, as the hot plates are served, the beverage in individual pots, dessert, bread, butter and milk are placed on the trays, which are transported to the patients, six at a time, on tray carts. Dry heat hot-plates are used for the hot dish and may also be used for chilled food in summer, to assure good service to the patient.

The trays are stripped in the pantry but all dishwashing is done in the central dishwashing unit, which is on the third floor of the new wing. Since it can be entered directly from the elevator, there are no transportation difficulties. Cups, glasses, teapots and soup bowls are carried in their respective racks, silver in stainless steel pans, and dishes on trucks of special design. The pantry floors are red quarry tile, the ceiling acoustic tile, and green enamel has been used on the plaster walls. The equipment includes a 27-cubic-foot refrigerator, a four-burner domestic stove, hot water urn, toasters, egg boilers, heated dish storage cupboard, self-levelling plate dispensers and adequate counter space.

Staff Cafeteria

Occupying one-half of the third floor of the new wing is the staff cafeteria. Operating on a pay basis, this cafeteria replaces seven dining areas previously in use. To serve the noon-hour peak load of 1,500 patrons, the equipment was designed and fabricated to



another fine hospital selects Clerk windows



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A floor pantry is located on each patient floor in the new wing. Modern equipment and a smooth work flow are highlights of these units. Elevator for the exclusive use of the dietary department is shown in the background at the right.

make use of the principle of pre-portioning wherever possible. The first supply of bulk food is transported from the main kitchen two floors above (in adjacent building) by the dietary elevator, and a dumb-waiter is used for timed orders throughout the meal. Supplies of hot foods are held in heat-and-humidity-controlled cabinets directly behind each hot food section of the counter. Portioning tables, built to specifications, for salads, fruits, desserts and juices, are all located behind the respective areas of pass-through refrigeration in the back bar. A separate

pass-through section for other desserts may be heated or not as desired. Two 10-gallon coffee urns and a 12-gallon hot water urn are located in the pantry and have dispensing taps on the wall.

A large walk-in refrigerator holds day supplies of food stores. The cafeteria counter has a total length of 120 feet in an elongated S-shape. As patrons enter they may take either of three possible lines of service with trays available from two stations. The first two lines go to hot food tables and the third may easily enter the

salad section where there is an auxiliary soup station. Desserts and juices are kept chilled on the "polar bar" area and the line becomes divided after this with tea and coffee on one side and the milk dispenser on the other side of the aisle. Silver and serviettes are available at both sides near the two cashier stations. The floor of the serving area is terrazzo.

The dining area has a capacity of 476 seats and provides a restful atmosphere for all personnel. Basically, decorating colours have been chosen to highlight the marble wall which holds the second tray stand. A glass screen has been erected which separates the service area from dining area and aids in eliminating noise. One long wall and all pillars are finished in wood veneer with a dull sheen. The east and west walls are plaster and have been painted in a light red tone. Table tops are finished in laminated wood plastic to resemble mahogany, and tables seat two or six persons. Walnut-stained chairs are upholstered on seat and back and are in two shades of green for contrast. The floor is asphalt tile of light grey with a border area of darker grey and the acoustic tile ceiling is painted white. The staff carry their own trays of soiled dishes to the conveyor belt placed at the exit of the cafeteria. Scraping of trays is done in a separate area on an assembly line basis and dishwashing is done in the central unit equipped with a conveyor-belt dishwasher. New dietary facilities also include spacious staff offices and rooms for dietetic interns on this floor.

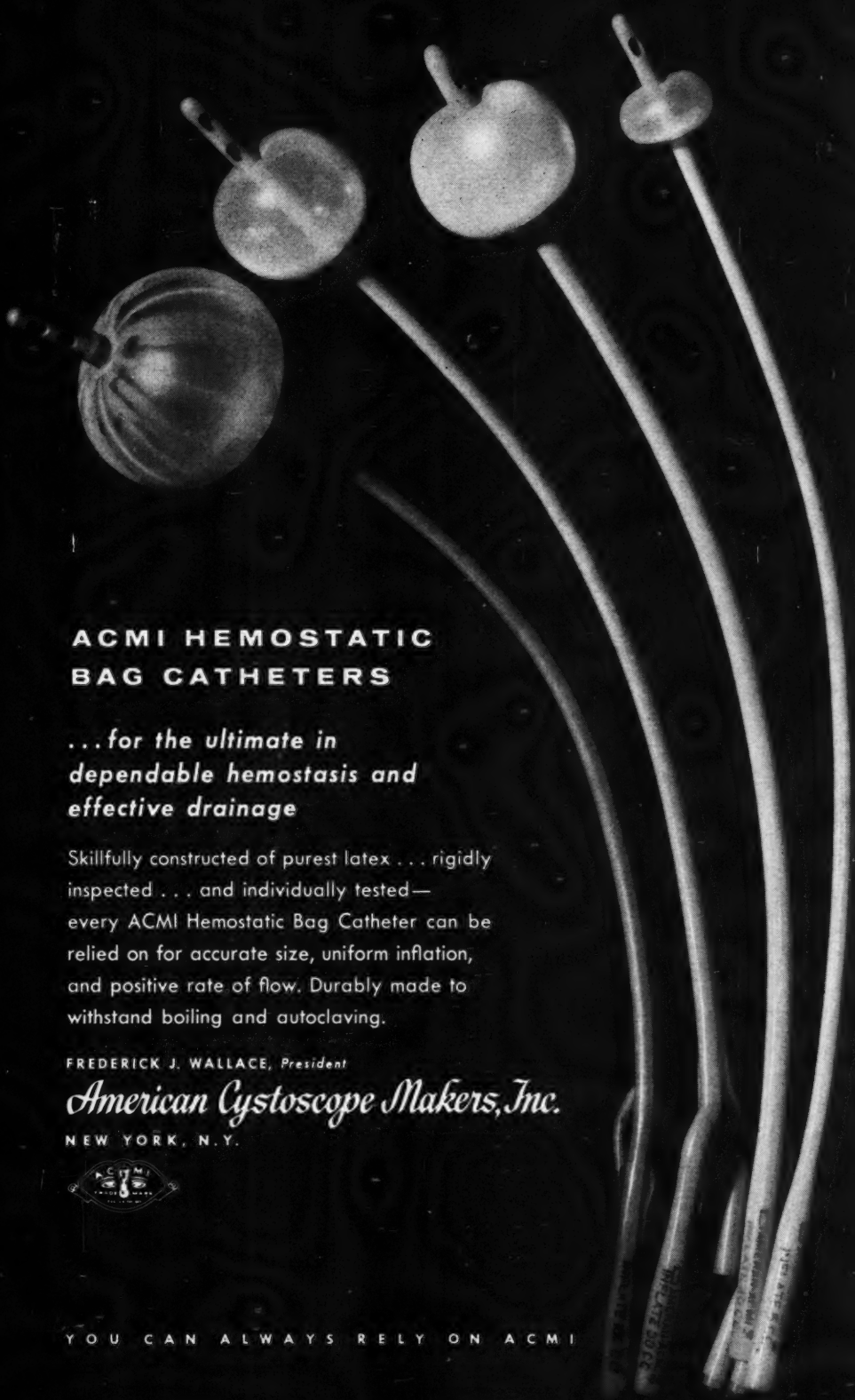
The writers wish to acknowledge that most of the credit for the organization and planning of these new facilities goes to Charlotte Large, who retired as director of dietetics at the Royal Victoria Hospital on December 31, 1955. Because of Miss Large's many years of experience and enthusiasm for continual study of adequate dietary facilities, only very minor changes from the planned routines have been required.



A section of the new main kitchen, showing stainless steel equipment and wide aisle space, which are among the many features of the area.

Regina Physical Restoration Centre

The Government of Saskatchewan's physical restoration centre at Regina has three departments: physical therapy, occupational therapy and speech therapy. It is staffed by medical and administrative directors, four physiotherapists, one occupational therapist, one social worker and several attendants and office personnel. Capable of handling 60 to 70 patients a day, this centre, as well as its twin in Saskatoon, is utilized to the limit, and expansion of both is being considered.



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ADMINISTERING a hospital is a far more difficult undertaking than most people realize — and apparently more than many trustees would seem to realize, judging by the selections sometimes made. Choosing the right administrator is not an easy task.

We expect much of an administrator. He must be a keen business man — understanding accounting, purchasing, collection methods, and business law. He must hold the confidence of his trustees, many of whom may be exacting industrialists or financial magnates. He must be skilled in personnel management and in human relations. He should be able to command the respect and loyalty of his medical staff, even though they may not be able to get along with one another. He must get along well with the nurses and with members of the women's auxiliary. He should be able to soothe the ruffled feelings of irate relatives; and to turn out a neat speech at a service club without making the mistake of using the word "I". He should understand the language of the radiologist, the biochemist, the engineer, and the laundry foreman. He must be a humanitarian first and not think of the hospital as a business only. He should be a student of social legislation, and of trends in welfare. Moreover his wife must be equipped with radar in order to steer an unbiased, yet not impersonal, course between the Scylla of the doctors' wives and the Charybdis of the other wives in town.

The administrator is to the hospital what the general manager is to a plant. In essence, he is the deputy of the board and acts on behalf of the board in the countless decisions which he must make day after day. In earlier decades there was a tendency for board members to take on some of the responsibilities now assumed by the administrator or one of his department heads. This is still done in some small hospitals where the superintendent, a nurse with perhaps no training or previous experience in administration, may find it impossible to direct and perform nursing activities and also assume all of the normal duties of the administrator. But, today, most boards expect the administrator to assume the generally accepted duties of that office.

Because we expect more of him today, it is vital that we take care to obtain the services of one who can

For Trustees Only:

A Crucial Choice

**Harvey Agnew*, M.D.,
LL.D., F.A.C.H.A.,
Prof. of Hospital Administration,
University of Toronto,
Toronto, Ont.**

do the job. A good administrator, as compared to a poor one, can do so much for the hospital that it more than pays to select a well-qualified person. I have known of several instances where salary expected was the determining and, apparently, almost sole criterion. That factor must be considered, of course, but to choose an unknown quantity at a lower figure rather than a thoroughly competent person may save, say, one or two thousand dollars a year—but may cost the hospital tens of thousands a year more than necessary (and untold amounts over the years), because of poor management, bad personnel relationships and low morale, lack of vision, and widespread public criticism.

Over the years we have been advisor to boards on many occasions; and also to young people, as well as seasoned administrators, seeking positions. We believe certain procedures or lines of action can be helpful.

In the first place, be very clear in your own mind what you expect the administrator to do. It is surprising how many boards are not quite sure what the responsibilities of the administrator are or what matters they should leave to him. Put them in writing, so that they can be discussed with applicants. If some member of the board is given executive or administrative responsibility, this should be made plain.

Committee

Name a small committee to interview applicants. Try to have all of the committee see each applicant, for it is very confusing if one has seen Jones and another Smith and a third Brown and not the others.

One of the problems in receiving applications is that of selecting the ones you wish to interview. Sometimes leading administrators, or the provincial or national association offices, can suggest a person who would fill the bill. Quite often this does not prove helpful. An advertisement in a hospital journal is apt to be seen by people already working in hospitals. Just

as in industry, the administrator you want is probably not in the ranks of the unemployed but is now working hard as an administrator or as an assistant somewhere else and would be willing to consider an opportunity which might spell advancement. Advertisements in the daily press will reach people inexperienced in hospital work and, to some extent, those in the field. Quite a few hospitals write, for suggestions, to the university schools conducting courses in hospital administration.

Today, some boards consult personnel placement services specializing in hospital executives. As an increasing number of well-qualified administrators or assistants are registered with these bureaux, it is a good way to contact qualified and experienced individuals interested in making a change. Normally the successful applicant pays a small percentage of his first year's salary to the bureau. Sometimes the hospital engages the director of a placement service to screen and select three or four for interview by the board. For this service it is becoming increasingly common for the hospital to pay the fee involved. Some bureaux simply send you a long list of names on their register and you do your own selecting. A few check your requirements very closely and send you selected names only; but each person suggested is one who could fill the bill.

Occasionally, names received from, or individuals recommended by, one of the hospital placement services are screened by one of the personnel advisory organizations or by a hospital consultant at the request of the hospital. If the firm truly understands what is needed in an administrator—and we stress this point—it can be really helpful and save the committee quite a bit of time.

You know the qualifications your position requires most. You may need a person who is primarily an organizer; or perhaps he must have a keen business instinct. Maybe a medical background would best meet the program undertaken by the hospital; perhaps a nurse administrator would be most suitable. You may need a conciliator or, on the other hand, a human stick of dynamite. It may be nec-

(Concluded on page 64)

* From an address to the Trustees' Section of the Ontario Hospital Association, October 25, 1955. Dr. Agnew is a member of the firm of hospital consultants, Agnew, Craig and Peckham.

BY

asorain &

harbonneau

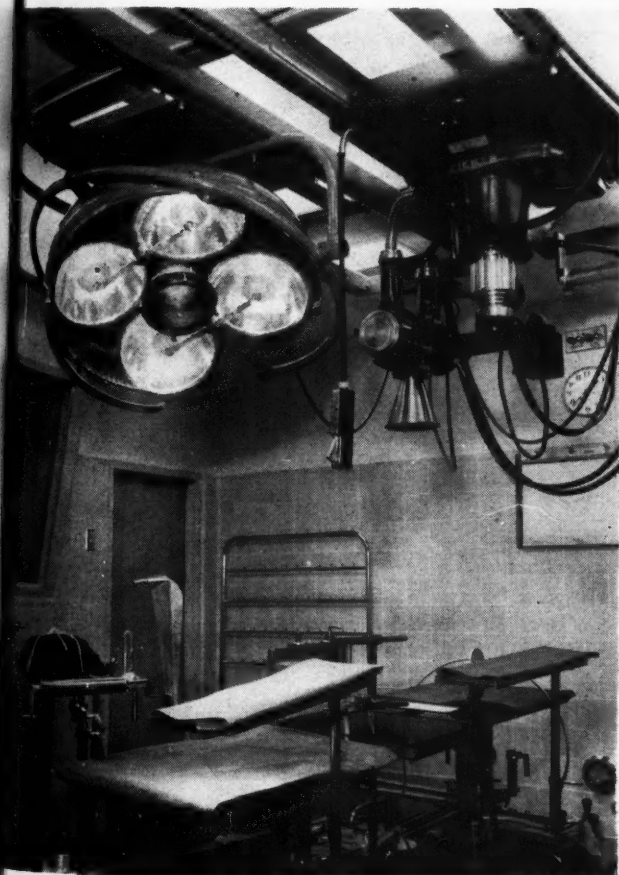
Ltée

Typical, one of twelve major operating rooms in this modern new wing is equipped with the Castle No. 62 Major Surgical Overhead Light. The Castle No. 62 permits repeated 360° horizontal rotation without stops and requires no tracks or dangerous counterweights.

The "secret" of this Castle Light lies in the multiplicity of light sources. By using four major reflectors of approximately 3000 foot-candles, plus a fifth center spotlight of an additional 1000 foot-candles, illumination is beamed to the field from over 100 points in the optical system, each individual beam having its own distinct focal length.

The four main reflectors operate on a 115 Volt A.C.-D.C. power unit, thus eliminating the hazard of power failure.

The special mounting shown here in the Royal Victoria Hospital, was designed by the Castle Co. and the Picker X-Ray Co. This No. 62 Light is used in conjunction with the overhead radiographic equipment. The operating light and the ceiling tube stand are mounted on special independent mobile carriages permitting quick transportation of either unit during surgery. These special combination mountings are felt to be an interesting and promising development, which should be widely copied as hospitals generally come to recognize the value of their application to the surgical suite.



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Hotel Dieu St. Vallier (Chicoutimi)
Hotel-Dieu du Christ-Roi (St. Joseph d'Alma)
Hopital Notre-Dame de Chartrre (Maria)
Hopital Ste. Famille (Ville Marie)
Hotel Dieu du S.C. de Jesus (Dolbeau)
Hotel-Dieu de Notre-Dame de L'Assomption
Hopital Laval (Quebec)

For Future Installation:

Hôpital Ste Justine (Montreal)
Hôpital Notre Dame (Montreal)
Hotel Dieu De Quebec
Hôpital Du Sacre Coeur (Hull)
St. Vincent De Paul "OBS. Dept."
(Sherbrooke)
Hôpital St. François (La Sarre, Que.)

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• MEDICAL, PHARMACEUTICAL & SCIENTIFIC CENTER

Crucial Choice (Concluded from page 60)

essary to weigh the merits of experience as against the potentialities of a recent graduate of a university course in hospital administration. You may even consider waiving any experience in the hospital field or any specialized training in hospital administration in favour of some outside person from the business field. However, we are seeing less and less of this today, as boards realize how essential it is for the administrator to have an intimate and working knowledge of the special problems of hospitals. This is particularly important in the case of a new hospital or one requiring extensive reorganization.

You may think that the writer, as head of the graduate course in hospital administration at the University of Toronto, would be strongly biased in favour of these specially trained men and women. We are enthusiastic about them, of course, and note with much pride how rapidly they are forging to the front in the administrative field; their specialized training is proving most helpful. However, we realize that training, no matter how good or complete, is only part of the picture.

Of major importance are the personal attributes of the individual. Good personal characteristics, plus reasonable hospital experience, may be what you most need. Training makes a good person still better and, other factors being equal, trained persons should develop more rapidly. But university training in itself will not replace personal attributes.

The Interview

As the candidates selected for in-

terview often live at a distance, it is customary for the board to wire them to come for interview at hospital expense.

At the interview the committee gains more knowledge of the applicant:

What is his personal appearance? Does he look competent? Will he inspire trust and confidence? Could his dress or manner be criticized by conservative townsmen?

What is his background of training in administration or of experience in administration? What has been his experience in business, if he has had that background? Does he know anything about hospitals?

What reputation has he—as an administrator, a physician or a business man? Has he been a success? Has he been a rolling stone? If he has moved several times, could it be that the board or the medical staff elsewhere have made it impossible for him to stay? That has happened, too. Has he a reputation of getting along well with people—or the reverse? Is he essentially a straightforward honest person?

Is he the leader type? Does he look and act as though he could think for himself and have the courage of his convictions? Has he a vision of what the hospital might do as an added service to the community? Or is he just a heel clicker? Busy boards need somebody to give them ideas; they will decide whether these ideas are feasible or not. Yet I know of a board that turned down a good man because they were afraid he would think up too many things for them to do. That man was lucky to be turned down!

Why is he in hospital administration—or wants to be? Is it just a job with him—to be left when something

more remunerative turns up—or is he primarily interested in choosing a position which will let him be of some service to his fellows? After World War II quite a number of ex-officers (medical and non-medical) inquired of us about administrative opportunities. Some were excellent types and have been well placed; but several admitted that they wanted "sit-down" jobs. Their names went in the basket.

Be frank with the selected applicant in the final screening. If you have a tough situation do not keep it from him. Whether it is finance, or personnel incompatibilities, or staff difficulties, or a disinterested board, or poor public relations, he should know what he is up against.

Recently an administrator accepted an offer to go to another hospital. He resigned his previous position and helped to find a successor. Just before he was to start his new work he was informed that the board had now decided to separate the administrative responsibilities, with two parties each directly responsible to the board—in other words, two captains on the bridge. This practice of dual control may have its place in industry; but in the hospital field it has been found very disrupting if one or the other is not made the titular head. The new appointee rightly protested that this was an unfair segmentation of the position he had accepted, and declined to assume the post. Meanwhile his former position had been filled and he was left looking for one.

In this country we are fortunate in that the Canadian Hospital Association has set up a two-year extension course in hospital organization and management which permits a large number of our administrators and their assistants, if recommended by their provincial association, to get some excellent training in hospital administration. This is taken at home and is supplemented by two summer sessions in some hospital centre. Many individuals who, for one reason or another, cannot take the graduate course at the university have been greatly helped by this course. It is confused at times with the University Course, possibly because our staff at the University works closely with the C.H.A. in the conduct of the extension course. They are, however, quite separate and have different entrance requirements and curricula.

In conclusion, do not treat the selection of an administrator lightly. It is a serious choice and nothing is further from the truth than the old statement that "any intelligent person should be able to run a hospital". •

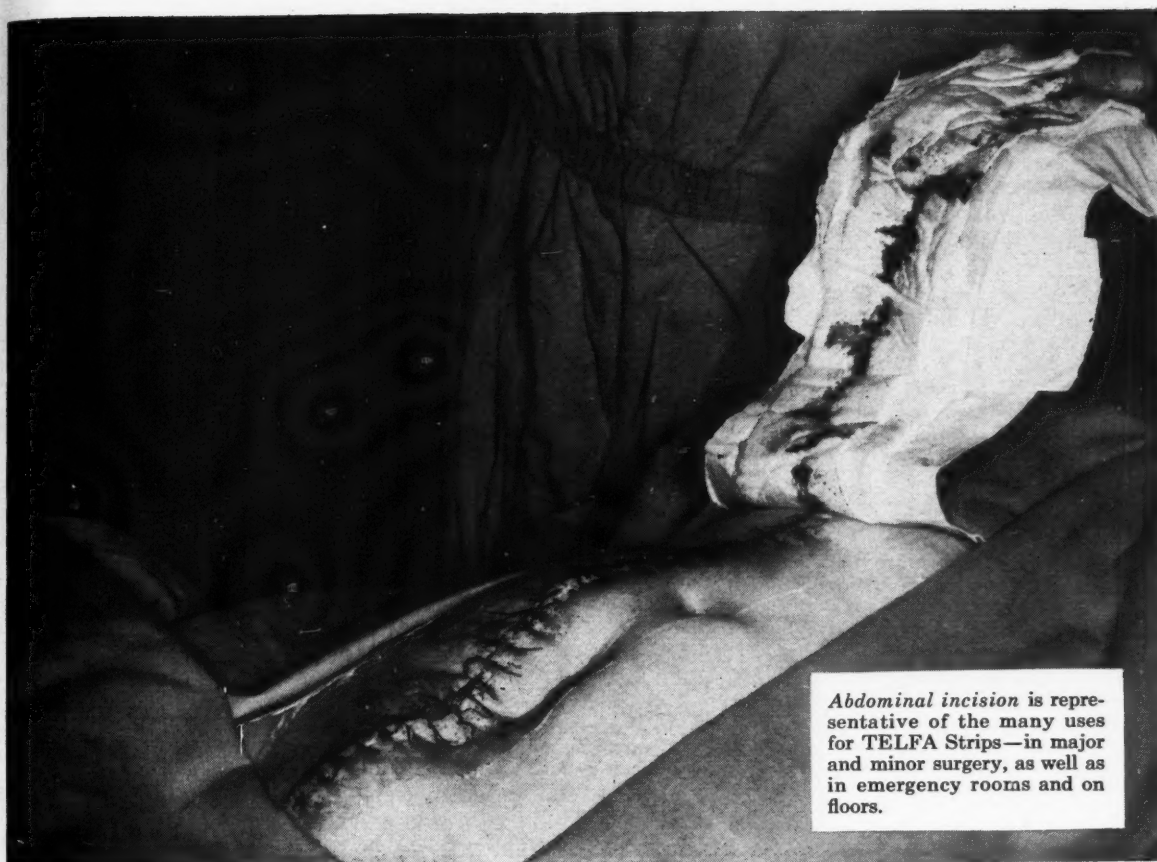
New Letters After Their Names

With the signature of the Lieutenant-Governor of the Province of Quebec now on the Dietitians' Act, that province leads all the others in granting professional status, by law, to fully trained dietitians. Now a dietitian having taken a post-graduate internship or a Master's degree and one year's experience has the right to use the name "professional dietitian" and to use the initials P.Dt. after her name. A dietitian holding her university degree but having taken no post graduate work is entitled to use only the name dietitian. Members of the Quebec Dietetic Association are pleased by this recognition of their high qualifications and the protection thus afforded them by law—since unqualified persons may not use the term nor any compound of such a name. It is expected

that dietitians in other provinces will press for similar legislation.

New C.N.I.B. Headquarters

A new 3.5 million-dollar rehabilitation centre, standing on a 10-acre site, which has been built in Toronto by the Canadian National Institute for the Blind is now completed. The centre occupies nearly one-quarter million square feet and it has an administration and general service building which is the C.N.I.B. National Headquarters, connected buildings for recreation and hobbies, a braille library and publishing house, an occupational training centre, kitchens and residential space for 140 blind persons. The main building is called Baker-Wood Hall after Col. E. A. Baker, O.B.E., managing director, and Mr. Lewis M. Wood, C.B.E.



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ings are economical too. They cost no more than conventional dressings, and save considerable doctor and nurse time in changing dressings.

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Conseil des Hôpitaux de Montréal

L'ANNEE qui se termine fut, pour notre Conseil des Hôpitaux de Montréal, très active. Si les problèmes nombreux et connexes qui surgissent constamment dans notre domaine n'ont pas tous été résolus, si tous nos projets ne se sont pas matérialisés, nous avons, néanmoins, la satisfaction d'avoir travaillé ferme à améliorer la situation présente.

C'est avec plaisir que nous avons appris l'ultime honneur décerné, au cours de l'année, à notre 1er vice-président, le Dr J. Gilbert Turner, à l'occasion de son accession à la présidence de l'Association des Hôpitaux du Canada, poste le plus élevé dans le domaine hospitalier du pays. Cette nomination qui rejaillit autant sur notre Province que sur notre Conseil, est suffisamment éloquente et se passe de commentaires. Qu'il nous suffise d'ajouter que le Dr Turner — qui a également été nommé représentant du Comité Conjoint de l'Association des Hôpitaux du Canada et de l'American Hospital Association et chargé des relations entre ces deux Associations — est une autorité en matière hospitalière; nous sommes donc heureux que ses mérites soient ainsi reconnus. Nous effrons au Dr Turner, avec nos chaleureuses félicitations, notre entière collaboration.

La nomination du Dr Paul Bourgeois à titre de directeur de l'Association des Hôpitaux du Canada, en vue de représenter l'élément canadien-français au sein de cette Association, honore également notre Conseil, et parle suffisamment en faveur de ce brillant collègue. Ladite Association a, de plus, désigné le Dr Bourgeois pour la représenter à la Commission Canadienne d'Accréditation. Nous prions donc ce dévoué collaborateur d'accepter les sincères félicitations de tout le Conseil.

Nous sommes heureux de souligner ici l'aménagement de plusieurs institutions-membres dans de nouveaux locaux. En effet, l'hôpital Montreal General, la Clinique B.C.G., l'hôpital Jeffery Hale, de Québec, ainsi que l'Institut Bruchési, un nouveau membre

J. H. Roy,
Président,

Le Conseil des Hôpitaux de Montréal,
Montréal, P.Q.

occupent maintenant des locaux spacieux et très modernes, facilitant ainsi la poursuite de leur oeuvre humanitaire.

Nous nous devons aussi de mentionner l'addition d'une aile des plus modernes à l'hôpital Royal Victoria. Quant aux hôpitaux Notre-Dame, Ste-Justine, Montreal Children, Royal Edward, Laurentian et Jewish Hospital of Hope, leurs travaux d'expansion progressent et bientôt, ces institutions pourront mettre à la disposition des malades, des centaines de lits nouveaux.

Une autre fondation toute récente, et combien louable, est celle dont Son Eminence le Cardinal Paul-Emile Léger vient de doter si généreusement notre Ville. Tous connaissent l'oeuvre hautement humanitaire à laquelle est voué l'hôpital St-Charles Borromée qui, tout en répondant à un réel besoin de la part des malades, décongestionnera nos services d'incurables et de chroniques occupant trop souvent des lits destinés à certain autres malades que nous ne pouvons recevoir, faute d'espace. Nos chaleureuses félicitations et voeux de succès s'adressent à Son Eminence qui a su prendre une si belle initiative.

Un problème qui, depuis longtemps déjà fait l'objet de démarches et de discussions, et dont la solution apporterait un grand bienfait à nos hôpitaux, est celui des cliniques externes fréquentées par les malades indigents. Cette question est, pour nous, d'un intérêt primordial puisque son poids pèse lourdement dans la balance de nos déficits. De nombreuses démarches entreprises dans le passé en vue de faire défrayer ces dépenses par les Gouvernements, n'ont donné, à date, aucun résultat tangible. C'est pourquoi, en vue de persuader les autorités compétentes du bien-fondé de nos réclamations, M. Paul Bienvenu, président du comité exécutif du Bureau d'Administration de l'hôpital Notre-Dame, convoquait, au cours de l'année, une réunion de présidents et d'administrateurs de plusieurs hôpitaux

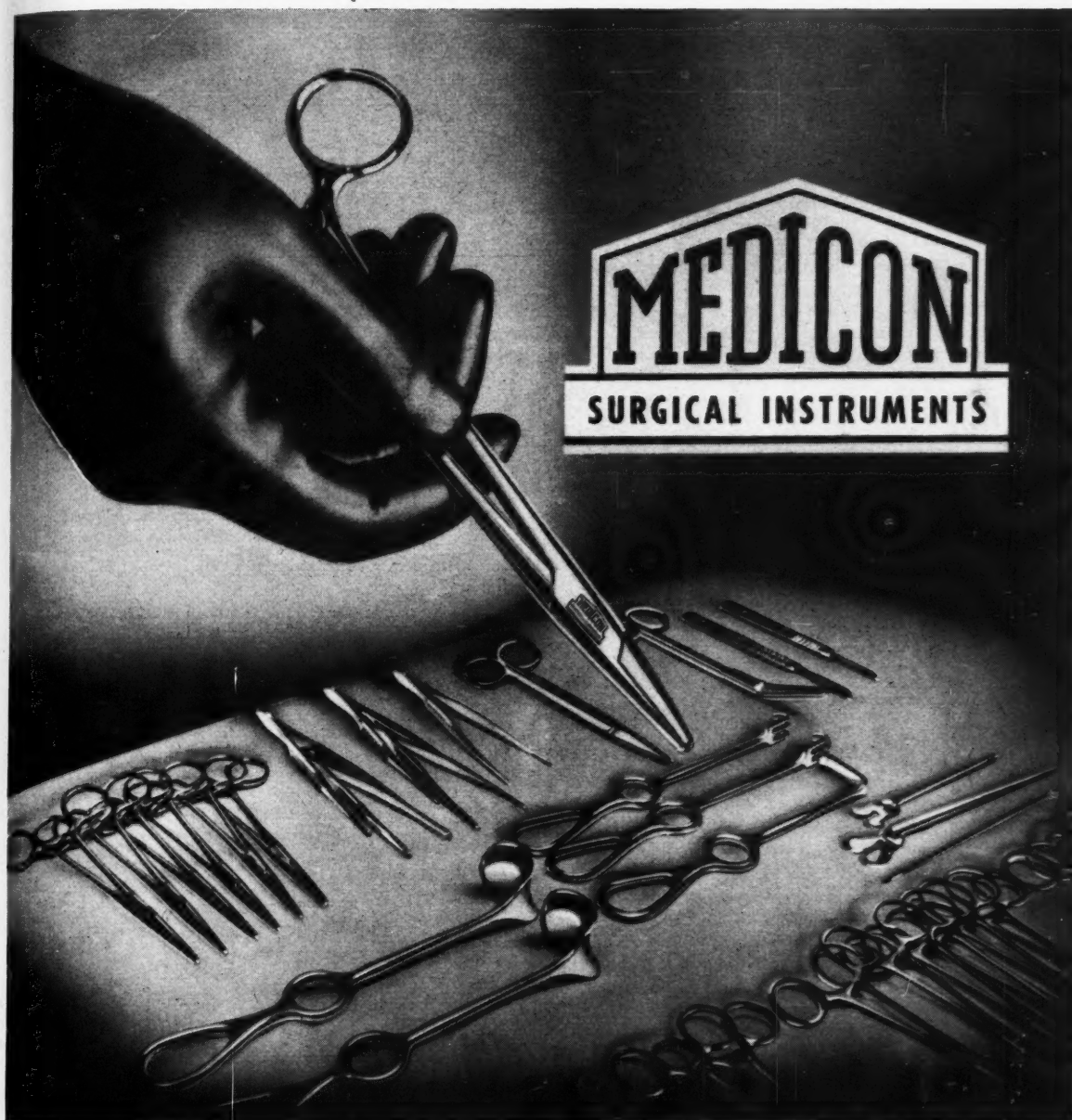
que nous sommes heureux d'accueillir, de Montréal. En vue de déterminer le coût réel de ces cliniques, il fut d'abord décidé que les institutions intéressées adoptent une comptabilité uniforme pour tablier ce coût. A cette fin, Paul Shannon, contrôleur à l'hôpital Royal Victoria, s'associa l'aide de comptables d'autres institutions, et, après un travail actif et constructif, une formule similaire fut acceptée par ces institutions. Ces mêmes institutions furent alors appelées à répondre à un questionnaire qui leur fut adressé à cet effet. L'on compila alors les réponses reçues et un mémoire fut préparé à l'intention des autorités. Certaines démarches furent alors laissées à la discrétion de M. Paul Bienvenu, dans le but de nous assurer une entrevue avec les autorités municipales, en vue de faire valoir nos demandes et de leur soumettre le mémoire spécialement préparé à leur intention, mémoire démontrant le nombre de visites faites à nos institutions, et le coût de revient de chacune de ces visites.

Quant au tarif d'hospitalisation des malades indigents, il n'a pas changé depuis 1954, et l'augmentation que l'on nous accorda alors était encore loin du coût réel qu'entraînent l'hospitalisation et les soins donnés à ces indigents. D'ailleurs, tant que la loi actuelle de l'assistance publique n'aura pas été amendée, nous ne pouvons compter être totalement remboursés de ce coût, car nous savons tous que cette loi stipule que l'institution intéressée — tout comme le gouvernement et la municipalité — doit supporter le tiers du coût de l'hospitalisation de l'indigent. Il faudrait donc que ladite loi soit amendée afin que ce coût soit défrayé par le gouvernement et la municipalité seulement, et qu'il ne soit pas fixé arbitrairement par le gouvernement, tel que la chose existe présentement.

Nous nous sommes récemment adressés à l'honorable Albini Paquette, ministre de la Santé, sollicitant une entrevue afin de discuter d'une augmentation adéquate de ce taux. Cet entretien fut alors fixé au 21 mars.

En ce qui a trait à l'assurance-hospitalisation dont le projet fut soumis par le gouvernement fédéral aux provinces désirants s'en prévaloir, en offra d'y contribuer dans une proportion de 50 pour cent nos institutions n'ignorent pas qu'elles seront appelées à jouer un rôle vital dans la réalisation du projet, bien que n'étant pas encore parfaitement au courant de ce que comporte ledit projet. Nous avons néanmoins offert à l'honorable Ministre de la Santé toute notre coopération dans l'étude de ce grand problème des soins médico-hospitaliers. En l'absence

Extrait du discours du président à l'assemblée annuelle du Conseil des Hôpitaux de Montréal, Inc., tenue le 22 mars 1956. M. Roy est aussi surintendant de l'Hôpital Saint-Luc, Montréal, P.Q.



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de l'honorable Paquette, son secrétaire a répondu que notre lettre serait soumise à l'attention du Ministre dès son retour à ses bureaux.

Au mois d'avril 1955, l'hôpital Notre-Dame, poursuivant ainsi l'heureuse initiative de notre Conseil, organisait à l'intention des hôpitaux de langue française, un institut ayant trait à la défense civile en cas de désastre. 42 hôpitaux y avaient délégué des représentants. Plusieurs personnalités de marque, dont Mgr Olivier Maurault, recteur de l'Université de Montréal, l'honorable Paul Martin, ministre fédéral de la santé, Son Honneur le maire Jean Drapeau, et des représentants du gouvernement provincial, rehaussèrent de leur présence cet Institut qui remporta un franc succès. Un simulacre de désastre, particulièrement réaliste, attira à ses organisateurs de très élogieux commentaires. A cette occasion, l'hôpital du Christ-Roi de Nicolet, soumit un plan de défense également très bien organisé.

Les autorités de l'hôpital Notre-Dame, et tout particulièrement son directeur-général, le Dr Paul Bourgeois, méritent des félicitations en marge de cette organisation.

En collaboration avec le service d'extension de l'Université de Montréal, un autre institut, d'une durée de trois jours, et ayant pour thème "Les Problèmes Juridiques dans nos Hôpitaux", fut également organisé au mois d'avril, à l'intention des hôpitaux de langue française. Des juges, des avocats, des médecins, etc., donnèrent alors des conférences très appréciées des 152 délégués inscrits à ce symposium, assistance la plus nombreuse inscrite, à date, aux instituts organisés par notre Conseil. Son Eminence le Cardinal Paul-Emile Léger, malgré ses occupations multiples, voulut bien honorer de sa présence cet Institut et adresser la parole aux délégués réunis à l'université de Montréal, en l'occurrence.

C'est au Dr Gérald LaSalle, notre secrétaire-général, que nous devons l'organisation de ce symposium pour lequel, de toutes parts de la Province, des félicitations nous sont parvenues. A la demande générale, un autre institut du même genre tiendra incessamment des assises en vue d'y discuter certains points qui n'ont pu l'être au cours des séances précédentes.

De concert avec les Doyens des Facultés de Droit et de Médecine de l'université McGill, des instituts similaires pour les hôpitaux de langue anglaise et de langue française, ont encore été projetés.

Soucieux de maintenir la bonne réputation de ses membres qui subissent, depuis quelque temps, la critique injuste de certains journaux, notre Con-

seil a décidé d'entreprendre une campagne d'éducation destinée à la presse et au public, en vue de faire connaître les difficultés de toutes sortes que rencontrent nos institutions dans la poursuite de leur oeuvre humanitaire. Pour inaugurer cette campagne, les membres du comité de notre Conseil exécutif convoquaient les quotidiens de Montréal, afin d'échanger leurs vues sur différents points. Après une discussion cordiale, il fut décidé d'établir un code en vue de faciliter le travail de renseignements que nos hôpitaux sont appelés à fournir quotidiennement aux journaux. Ce code fut rédigé par notre aviseur légal, et des copies en furent distribuées aux hôpitaux et aux journaux. Nous espérons ainsi promouvoir, dans une certaine mesure, nos relations avec les journaux, d'autant plus qu'à nos prochains symposiums, nous nous proposons de pousser plus à fond l'étude du code de presse.

Depuis plusieurs années déjà, notre Conseil préconise une association de tous les hôpitaux de la Province. A date, plusieurs tentatives en ce sens furent infructueuses. Tous, nous savons que, dans la Province, nos hôpitaux

sont présentement groupés en cinq associations différentes qui divisent nos activités, et par le fait même, diminuent notre influence lorsque nous nous présentons devant les autorités provinciales ou autres. Depuis quelques semaines, cependant, un nouveau mouvement se dessine, et, avec l'assentiment des autorités, je suis en mesure d'affirmer qu'un ardent désir de grouper en une association solide tous les hôpitaux de la province, existe présentement, et que la matérialisation de ce projet serait favorablement accueillie de tous les intéressés. Cette réalisation fera certainement époque dans le monde hospitalier de la Province.

Nous sommes heureux de féliciter ici l'université de Montréal de l'initiative qu'elle vient de prendre en fondant une école d'administration hospitalière qui rendra d'immenses services à ceux qui se destinent à la carrière d'administrateur d'hôpitaux. Le Dr Gérald LaSalle, notre secrétaire-général, mérite des félicitations en marge du travail qu'il a accompli en persuadant les autorités universitaires de la nécessité de cette école.



Presidential address to the

Montreal Hospital Council

THE year just ended was one of great activity for our Montreal Hospital Council. If the numerous correlated problems which crop up continuously in our field of endeavour have not all been effectively solved nor our plans entirely materialized, we, nevertheless, have the satisfaction of having worked steadfastly to improve conditions.

It is a pleasure to note the establishment of several member-institutions in new quarters. The Montreal General Hospital, the B.C.G. Clinic, l'Institut Bruchési, a new member which we welcome heartily, and the Jeffery Hale Hospital, of the City of Quebec, occupy modern new buildings which make more feasible the pursuance of their humane tasks. Royal Victoria Hospital recently completed an up-to-date additional wing section to their general hospital building.

From the presidential address at the annual meeting of the Montreal Hospital Council, held March 22, 1956. Mr. Roy is also superintendent of St Luke's Hospital, Montreal, P.Q.

J. H. Roy,
President,
Montreal Hospital Council Inc.
Montreal, P.Q.

Construction programs are progressing at Notre-Dame, Ste-Justine, Montreal Children's, Royal Edward Laurentian and the Jewish Hospital of Hope, which soon will enable these hospitals to place hundreds of additional beds at the disposal of new patients.

The foundation sponsored by His Eminence Cardinal Paul-Emile Léger is praiseworthy and deserving of special mention. We all know the purpose to which Hôpital St-Charles Borromée (of which Cardinal Léger is the founder) will be dedicated; it fills a most urgent need in caring for chronic and incurable diseases, thus making beds available in other hospitals for patients who cannot now be admitted through lack of space.

(Continued on page 72)

for survival!



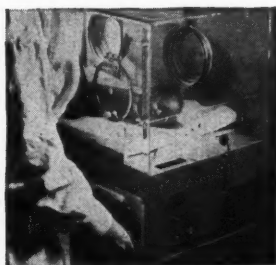
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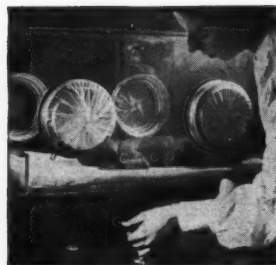
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(Continued from page 68)

A problem which has been under study and the subject of numerous discussions over a period of several years, and which when solved will be of untold benefit to our hospitals, is that of outpatient clinics for indigent persons. This question is highly important inasmuch as the cost of maintaining out-patient clinics weighs most heavily on the scale of our annual deficits.

All endeavours to have the said expenses borne by our governments have failed. In order to convince the authorities concerned of the justice of our claims, Mr. Paul Bienvenu, President of the Executive Committee of Notre-Dame Hospital Board of Directors, held a meeting of presidents and administrators of a number of Montreal Hospitals at which it was resolved that a uniform system of accounting should be adopted for the use of all our hospitals, to determine precise operating costs of outpatient clinics. Paul Shannon, who is comptroller at Royal Victoria Hospital, enlisted the assistance of accountants of other hospitals and, following constructive study of the problem, they developed and submitted to us a cost formula. Following its approval, our hospital executives completed a questionnaire on the subject. Their replies were compiled in a memorandum prepared for presentation to the governmental authorities.

Mr. Paul Bienvenu undertook to arrange for a hearing with the municipal authorities to press our claims, supported by the said memorandum setting out clearly the number of patients treated at each hospital and the cost of treatments, given in outpatient clinics, which should be reimbursed.

Regarding the rates payable to hospitals for the hospitalization of needy patients, these remain unchanged since 1954 when the increase granted fell far short of actual cost of hospitalization and treatment. Moreover, as long as the Public Charity Act remains unchanged it is useless to expect total reimbursement of outlay, as this law stipulates that the hospitals concerned, the provincial government and the municipality, shall each bear one-third of the cost of hospitalizing needy patients. Therefore, this law should be amended so as to make the province and the municipality alone liable for actual costs instead of having the rate set arbitrarily by the government.

Recently, the Honourable Albini Paquette, provincial Minister of Health, was approached regarding a meeting to discuss the question of an adequate increase in the hospitalization rate for indigent patients. The

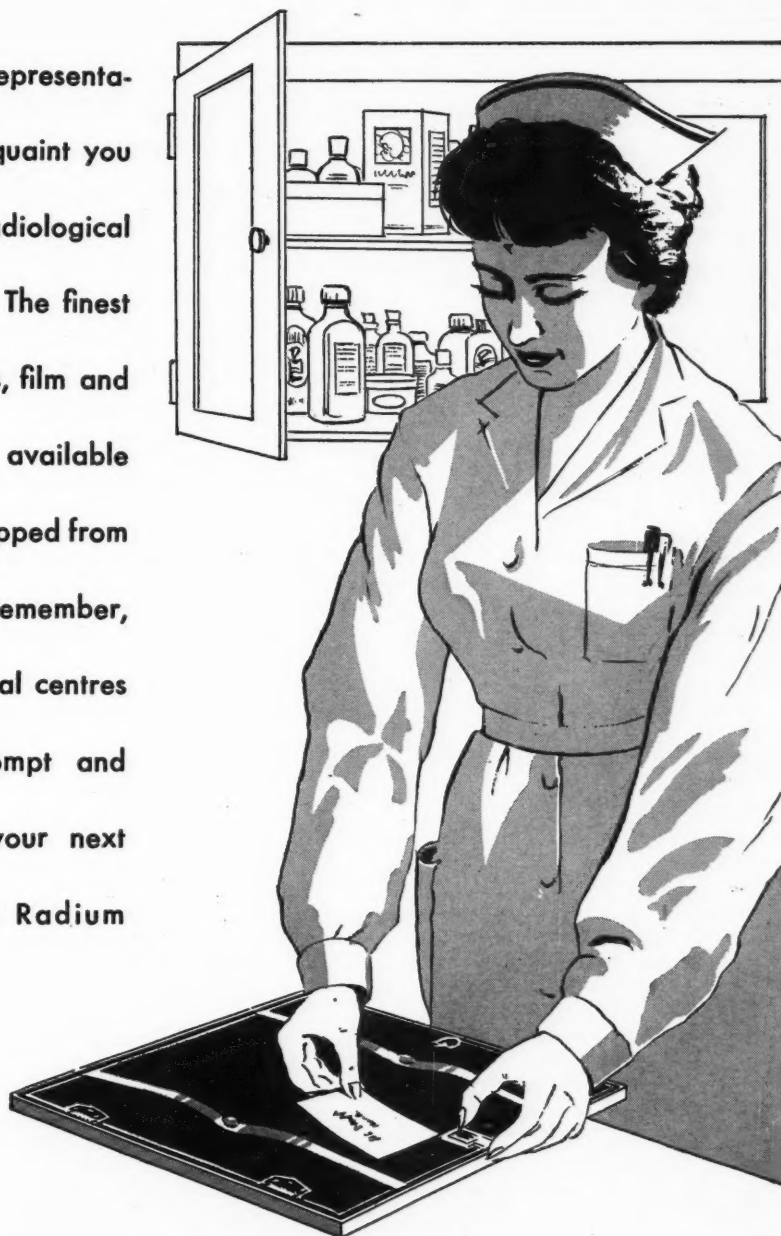
(Continued on page 108)

Coming Conventions

- May 21-24—Catholic Hospital Association of the United States and Canada, annual meeting, Milwaukee, Wis.
- May 29-31—Canadian Public Health Association, Admiral Beatty Hotel, Saint John, N.B.
- May 29-31—Maritime Hospital Association Convention, Algonquin Hotel, St. Andrews, N.B.
- June 9-10—Catholic Hospital Conference of British Columbia, Vancouver, B.C.
- June 11-15—Western Canada Institute, University of British Columbia, Vancouver, B.C.
- June 11-15—Canadian Medical Association, Ecole de Commerce, Quebec City, P.Q.
- June 13-15—Annual Convention British Columbia Hospital Auxiliaries, Brock Hall, University of British Columbia, Vancouver, B.C.
- June 14-15—Canadian Heart Association, Quebec City, P.Q.
- June 15-16—Canadian Association of Pathologists, Quebec City, P.Q.
- June 16—British Columbia Hospitals' Association, University of British Columbia, Vancouver, B.C.
- June 16-20—Canadian Orthopaedic Association, Edmonton, Alberta, and Jasper Park Lodge, Jasper.
- June 17-20—Canadian Foundation for Poliomyelitis, Vancouver, B.C.
- June 17-21—First North American Conference for Medical Laboratory Technologists, Chateau Frontenac, Quebec, P.Q.
- June 17-23—Second Congress of the World Confederation for Physical Therapy, Hotel Statler, New York City.
- June 18-20—Canadian Anaesthetists' Society, Mont Tremblant, P.Q.
- June 25-27—Annual Meeting of the Comite des Hopitaux du Quebec, Salle du Manège Militaire, Quebec, P.Q.
- June 25-29—Biennial Meeting of the Canadian Nurses' Association, University of Manitoba, Winnipeg, Man.
- June 26-28—Canadian Dietetic Association, Macdonald Hotel, Edmonton, Alta.
- Aug. 12—Canadian Society of Hospital Pharmacists, Ottawa, Ont.
- Aug. 29-Sept. 1—Canadian Society of Radiological Technicians, Empress Hotel, Victoria, B.C.
- Sept. 15-19—American College of Hospital Administrators Annual Meeting, Palmer House, Chicago.
- Sept. 17-20—American Hospital Association Convention, Chicago, Ill.
- Sept. 17-20—American Association of Hospital Consultants, Palmer House, Chicago, Ill.
- Oct 1-5—International Congress on Medical Records, Shoreham Hotel, Washington, D.C.
- Oct. 10-12—Convention, Canadian Association of Medical Record Librarians, Vancouver, B.C.
- Oct. 16-18—Associated Hospitals of Alberta, Macdonald Hotel, Edmonton.
- Oct. 22-24—Ontario Hospital Association Convention, Royal York Hotel, Toronto, Ont.
- Oct. 24-26—Saskatchewan Hospital Association Convention, Bessborough Hotel, Saskatoon, Sask.
- Oct. 27-29—Canadian Association of Occupational Therapy, Montreal, P.Q.
- Oct. 30-Nov. 1—Manitoba Hospital and Nursing Conference, Winnipeg, Man.
- Nov. 1-2—A. H. A. Institute on Operating Problems of Small Hospitals, Winnipeg, Man.

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◀ Provincial Notes ▶

Newfoundland

CARBONEAR. A 15-bed hospital is to be built here this year as a result of community action backed by financial assistance from the Newfoundland government and the Canadian Red Cross. The town of about 3,500, situated on the east coast of Conception Bay, has undertaken to collect \$25,000. The balance of \$42,000 will be met by the provincial government.

ST. JOHN'S. A tentative arrangement has been made for a new \$500,000 cancer clinic to be built as an annex to St. John's General Hospital. A two-section addition for the clinic will be built between the new and the old parts of the hospital. The cobalt bomb for cancer treatment and a division of pathology will be in the basement. The top floor will be the clinic itself, for diagnosis and treatment. Montreal architects currently are working out the details for the clinic and officials hope construction will begin this year.

Nova Scotia

DIGBY. A new tuberculosis x-ray unit will be installed by the provincial department of health at the Digby General Hospital. Valued at \$12,000, the unit will permit every patient admitted to the hospital to receive a free chest x-ray and any person requiring a chest x-ray will be privileged to have one without cost at any time.

HALIFAX. Oxygen will be piped to every required section in the Victoria General Hospital and the Halifax Children's Hospital under a joint program that has been arranged. The newer section of the Children's Hospital already is piped for oxygen and work of installing the equipment in other parts of the building is well advanced. Most of the equipment is on hand at the Victoria General Hospital where the oxygen will be stored in a special trailer tank of 30,000 cubic foot capacity. When the work is completed there will be an instantaneous

source of supply available for every patient in the two hospitals.

New Brunswick

PLASTER ROCK. Construction is to start this month on the new 25-bed Tobique Valley Hospital which is expected to be completed in the fall. It will be located on the outskirts of town, on the Plaster Rock-Perth highway. Up until 1948 this community had no hospital to serve the 5,000 residents of the area. In that year a Red Cross outpost hospital was established, providing 10 rooms in a converted house. This structure burned in 1954. Since then the hospital has been occupying a boarding house. The new two-storey hospital will provide a paediatric section, nursery, operating room, outpatient department, x-ray department, and living quarters for 12 nurses. Alward and Gillies, Saint John, are architects for the project.

SAINT JOHN. Progress is reported in construction of the new St. Joseph's Hospital building. It is expected to be completed, at a cost of more than \$3,200,000 by mid-1957, at which time the present main hospital building will become a combined nurses' residence and nursing school.

Quebec

MONTREAL. The Jean Talon Hospital in Montreal, serving the north central area of the city, was opened a little more than a year ago with 94 beds and 13 bassinets. It has been operating at 95 per cent capacity and serves an estimated population of 293,000. Work is now in progress on a new wing which will bring the capacity to 120 beds and 75 bassinets. This will also extend the outpatient department facilities to handle 300 patients a day.

ST. HILAIRE. Dieppe House, a hospital designed exclusively for epileptics, recently ran a campaign for \$75,000 to increase space for work-rooms and bedrooms. The hospital was founded ten years ago as a memorial to Canadians killed at Dieppe. An

extension to the hospital, scheduled to be opened in July, will add 50 beds to its present capacity of 82. The patients learn leather-work, shoe-making, weaving, carpentry and painting. They grow food on the hospital's 170 acres, and raise money by selling their handicrafts. Since the hospital was opened, more than a quarter of its patients have improved enough to return home. Some have been almost fully rehabilitated.

Ontario

BRAMPTON. Construction of a new five-storey wing for Peel Memorial hospital will increase the capacity from 78 beds to at least 150 beds. The Hospital which opened 31 years ago with 12 beds, serves more than 50,000 persons. Cost of the new wing will exceed \$1,000,000.

LINDSAY. Architects are working on proposed expansion plans for the Ross Memorial Hospital. The submitted estimated cost of the project would be \$1,150,000 to \$1,175,000. This would give the needed 120-bed capacity — with planned modern facilities which are now badly needed for the best efficiency.

NEWMARKET. A new \$750,000 wing of York County Hospital was recently opened. The addition to the 30-year old hospital increased accommodation from 54 to 128 beds and permitted enlargement of the nursery, laboratory, x-ray department, emergency section and maternity ward.

SMITHS FALLS. Construction of a 50-bed, \$460,000 addition at Smiths Falls Public Hospital is to start early in July. A \$90,000 heating plant has already been constructed as part of the \$550,000 program of modernization.

Manitoba

PORTAGE LA PRAIRIE. A new nurses' residence has been completed at the Manitoba home for mentally defective persons. It will accommodate 39 nurses, required to take care of the additional 159 female patients to be housed in a new unit to be completed in September. Total cost of the nurses' residence was \$147,900. The new unit for patients will cost \$647,500.

VITA. Cruise Memorial Hospital has been re-opened, having been com-

(Concluded on page 78)

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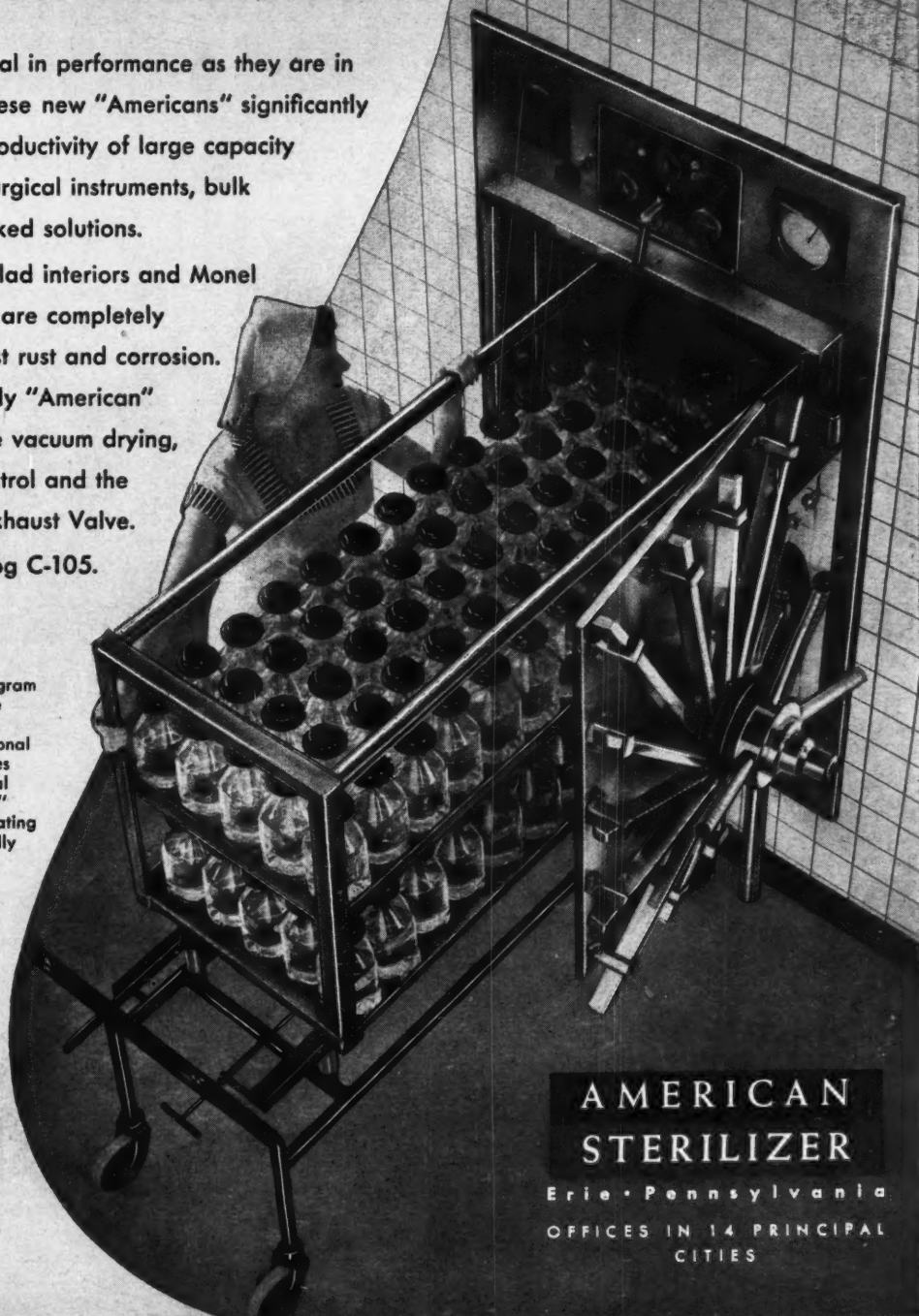
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(Concluded from page 76)

pletely rebuilt and remodelled following the tornado which ravaged the hospital last June. There are now 18 beds, 8 bassinets and 2 cribs.

WINNIPEG. King Edward Memorial Hospital has been officially reopened after 1½ years under renovation. Originally a tuberculosis hospital, King Edward now will be used for the care of the chronically ill. Cost of the project was \$230,000. Architects were Moody and Moore.

WINNIPEG. In final stages of decoration is the Jewish Old Folks' Home. The new 34-bed hospital wing is equipped with a built-in electronic "listening post" in each room, enabling a feeble patient to signal for assistance with utmost ease.

Saskatchewan

GULL LAKE. Federal and provincial grants have been approved to help the Gull Lake Union Hospital board in the building of a 12-bed unit here. The unit will have a bed set aside for maternity cases, and five nursing cubicles. There will be an area 740 feet square for outpatient treatment.

SWIFT CURRENT. Plans are being made to build an addition to Swift Current Union Hospital. The expansion is expected to cost \$316,000. Also planned is a new nurses' residence at a cost of \$271,000 and a home for the aged costing \$600,000.

Alberta

CAMROSE. Plans are proceeding for construction of a 50-bed addition to Bethany Sunset Home here. Being designed by Edmonton architects Blakey, Blakey, and Ascher, the new section, which will house chronic patients, will be attached to the existing building at the end of the east wing. It will also house a chapel and recreation room.

CLARESHOLM. A one-storey hospital building of 32-bed capacity is hoped to be in operation by next November. The approximate cost is between \$210,000 and \$220,000. Also planned on the same site is the erection of cottages for elderly people. These small units would be adapted to elderly couples, or two elderly women or men of similar tastes. They would be visited once a day by the hospital staff to see that all was well.

EDMONTON. Construction of a new rehabilitation unit at the University of Alberta Hospital is under way. It will have a capacity of 253 beds

and eleven bassinets. The total estimated cost of this structure including equipment, will be approximately \$4,000,000. It is anticipated that the building will be ready for occupancy by July of this year.

EDMONTON. An addition to the University of Alberta Hospital Nurses' Home has been commenced to provide 110 beds for nurses, lecture, and demonstration rooms, as well as a new teaching laboratory and gymnasium. The total cost of the new addition will be approximately \$635,000 when finished.

FAIRVIEW. An eleven-bed addition to the Municipal Hospital here will include a new solarium, public waiting room, administration offices, matron's office and outpatient department. Additional staff quarters, as well as larger kitchen and laundry facilities are planned. The estimated cost is \$85,000.

MEDICINE HAT. A proposal to add a sixth floor to Medicine Hat District Municipal Hospital, now under construction, to boost capacity by another 60 adult beds, is under consideration. The present 250-bed structure is of five floors, including basement which will house kitchen, cafeteria, laundry, service facilities, and several clinics. It is being built at a cost of \$3,000,000.

MEDICINE HAT. Construction of a \$600,000 nurses' home, incorporating a school of nursing, is to be completed in the early fall. Plans call for the construction of a two-storey, rambling ranch-style structure, to have accommodation for 105 nurses' beds, suites of rooms for the house mother and the director of nursing, instruction rooms, classrooms, and recreation rooms. First-year students will have double rooms, while second and third-year nurses will have single rooms. Architects are Rule, Wynn and Rule, of Calgary and Edmonton.

OLDS. Approval has been given to the plan of the Olds Hospital board to build a \$100,000-addition to the local hospital. The new 38 feet x 95 feet wing will enable the hospital to serve the needs of the entire hospital district.

British Columbia

BURNABY. Construction is expected to begin this year on a \$1,000,000 to \$1,250,000 addition to Burnaby General Hospital on the outskirts of greater Vancouver. The new building will be erected adjacent to the present

structure and will provide for 125 beds and 125 bassinets, doubling the present capacity of the hospital. Construction will take between 16 and 17 months. Architects are Gardiner, Thornton, Gathe and Associates, Vancouver.

ESSONDALE. Erection of a 100-bed nurses' home and training centre is proposed for the Provincial Mental Hospital at Essondale. To measure 345 feet in length, with a width of 54 feet at one end and 106 feet at the other, the building will be of reinforced concrete construction with brick facing. Cost of the project is likely to exceed \$1,000,000.

HANEY. Construction of a \$1,200,000 hospital is expected to start here this summer. Sketch plans for the structure have been completed by architects Thompson, Berwick, Pratt, Vancouver. Plans show a double-corridor hospital structure with facilities for 60 beds and 14 bassinets.

INVERMERE. Contract has been awarded for erection of a new 24-bed hospital here. It was designed by architect Paul D. Smith of Trail.

LILLOOET. Following "approval in principle" for a hospital here, architects Allan W. Gray and Associates, Vancouver, have been appointed to prepare tentative plans for the project. The 12-bed hospital will be designed so that additional units of accommodation for patients can be added without any alterations to the initial structure.

PORT COQUITLAM. A new hospital unit is to be erected at the Home for the Aged here. Designed by the staff of Clive D. Campbell, chief architect and deputy minister of public works, Victoria, plans show a four-storey reinforced concrete building with space for 300 beds, day rooms, auditorium, physiotherapy, laboratory, and dispensary facilities.

VANCOUVER. Construction is now under way on the new, 504-bed 10-storey building that will give the Vancouver General Hospital, at cost of \$7,500,000 more than 1800-bed capacity. Origin of the General was a nine-bed wooden building in 1886 that catered to the medical needs of workmen extending the CPR from Port Moody to Vancouver. Today the hospital has 22 buildings and sprawls over seven acres. (See *The Canadian Hospital*, January, page 50.)

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With the Auxiliaries

New Members in Manitoba

Three new groups have joined the ranks of Manitoba Women's Hospital Auxiliaries Association during recent months. The first is at Netley and serves the Selkirk Hospital. Another is the "Dales" Auxiliary which is derived from two districts, Meadowdale and Cloverdale, also serving the Selkirk area.

The third new member is the auxiliary to St. Boniface Hospital comprising 129 active and several hundred supporting members. Here, students from St. Mary's and St. Joseph's Academies work as volunteers on Saturdays. Service to the patients forms the greater part of the auxiliary's work. Volunteers work daily in the Kiddies' Korner, others arrange and distribute bouquets of flowers. Still others give their time to making surgical dressings, solutions, and sterilizing supplies. A recent undertaking has been the replenishing of the library and a committee is busy now covering and indexing a large number of books donated by the members. A beginning has been made towards assisting with occupational therapy in the psychiatric ward.

"You Can't Take It With You" — Or Can You?

A timely word of warning was issued to all Ajax and Pickering menfolk. "Watch your wardrobe, guard that old pair of comfortable slippers, keep a close eye on anything around the house that you have, belonging to you, that you cherish. Otherwise it may cost you money to get it back." The cause for alarm? The Ladies Auxiliary to the Ajax and Pickering General Hospital, Ajax Ont., were holding a monster "Rummage Sale" and had laid their plans with all the care and precision of an attack at dawn. Among the loot the ladies obtained was a piano!

Superfluity Shop

A project of the Women's Hospital Auxiliary to the Pontiac Community Hospital, Shawville, Quebec, is the opening of a superfluity shop for the sale of new and second-hand goods, the profits from which swell the funds of the hospital. A building having been secured and renovated, for the shop, a canvass will be made periodically for all kinds of articles which house-

holders do not wish to use any more. These will be repaired or renovated and sold in the shop. "Desirables" include furniture, clothing, dishes, wall paper, china, hats, and shoes.

One-day-olds

A department of baby photography has been operating for the past two years in the Maternity Pavilion of the Winnipeg General Hospital. Working under the auspices of the White Cross Guild a professional photographer, a lady, takes pictures of one-day-old babies behind a window. These are developed and next day delivered to the mothers, who may place orders for prints if desired. The cost is nominal and the idea has proved so popular that the guild has found it highly profitable.

Purchase Government Bond

The Women's Auxiliary to Prince Edward County Hospital, Picton, Ont., has purchased a two thousand dollar government bond, which is to be used for linens for the new hospital. They are buying, at the suggestion of the medical staff, a portable electric suction pump.

Annual Affair

An annual Vanity Fair held in Hanover, Ontario, netted about \$1,500 for the Hanover Hospital Women's Auxiliary recently. Local and district organizations co-operated in preparing the booths and raffles where articles were sold during the afternoon. A Smorgasbord supper served from 5:30 to 7:30 concluded the busy day.

Three New Affiliations in B.C.

New groups joining the British Columbia Hospitals' Association recently are: Duncan Junior Auxiliary, Maple Ridge (Haney) where their hospital is still in the planning stage, and Salmon Arm Senior Group which is re-joining after several years.

Versatile Group

The Women's Auxiliary of the Toronto General Hospital, Toronto, Ontario, opened a new shop on March 21st, to provide a service for patients and visitors to the hospital and to make money for still greater service.

Its cart already carries toilet articles, candy and magazines, but the shop will have a more varied stock, ranging from greeting cards to beautifully knitted baby things made by the auxiliary members. Already 90 volunteer workers have been signed up for shop duty. Two hundred and ninety volunteers work at all sorts of other tasks around the hospital. They do clerical work in the clinics. They sew and knit for mothers and babies in the Burnside Wing. They make dressings. They act as interpreters. They drive patients to and from clinics. They even pay for special diets or supply dentures or glasses or artificial limbs for patients who cannot afford them.

Auxiliary Buys New Equipment

The Fergus Women's Auxiliary of the Groves Memorial Community Hospital, Fergus, Ontario, has voted to purchase for the new hospital equipment designed to lift an injured person from the ambulance into the hospital. It is also widely used in lifting heavier, bed-ridden, patients. It is of particular aid in a hospital where there are no orderlies to help with the lifting of helpless patients.

Auxiliary Re-established

After a few years of inaction, the Women's Auxiliary to Willow Bunch Union Hospital, Willow Bunch, Saskatchewan, was revived recently by a small group of ladies of the community. As a first project, a house-to-house canvass was decided upon to obtain funds to supply the hospital with drapes.

Treasure-trove at Fun Fair

The auxiliary to Morden District General Hospital, Morden, Man., reports that its biggest fund-raising project for the year is the ever popular Fun Fair. Last year they added, as the main draw for the event, a chest filled with gifts donated by local merchants. It was a great success and the net intake was \$1,759.

Old Sale with a New Look

The "new look" in sales is fashionable among the members of the Junior Hospital Auxiliary to Chilliwack General Hospital, Chilliwack, B.C. Good, outgrown children's clothing is brought by the members, ready-marked with price and size, and is sold to other members before the meeting, with all proceeds going toward hospital equipment.



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◀ Book Reviews ▶

THE ADMINISTRATION OF HEALTH INSURANCE IN CANADA. By Malcolm G. Taylor. Price \$5.00. Pp. 270. Published by Oxford University Press, Toronto, 1956.

Malcolm G. Taylor is no stranger to the Canadian hospital field. He is widely recognized as one of the foremost authorities on health insurance in Canada and has been a contributor to professional journals in Canada and the United States. A native of Alberta, he is a graduate of the University of Alberta and of the University of California where he received his Ph.D. degree. For three years he was director of research for the Saskatchewan Health Services Planning Commission; and he has also acted as a consultant in health insurance to governments of other provinces and to a number of professional associations and health insurance agencies. On the faculty of the University of Toronto, he is assistant professor in the Department of Political Economy, and a lecturer at the School of Hygiene and the School of Nursing.

With the subject of national health insurance in Canada so much in the news these past few months, the publication of this book is extremely timely.

In *The Administration of Health Insurance in Canada*, Dr. Taylor examines objectives, achievements, and problems of the various health insurance plans; how they are organized, administered and regulated; the problems of enrolment and controls; how benefits are determined and premiums set; and how these plans affect the interests of patients, doctors, and hospitals.

At the present time health insurance is an accomplished fact for many Canadians, as voluntary plans, commercial insurance companies, and government-sponsored programs have experimented over the past 20 years in prepayment for both medical and hospital care. The book recounts the experience of the various plans in meeting the difficulties inherent in administering the most complex of the "social insurances". The study deals primarily with the Blue Cross hospital care plans, the medical care plans sponsored by the provincial medical associations, and the plans operated by provincial governments.

One of the author's conclusions is that, in setting up a province-wide

compulsory hospital insurance plan, the legislature concerned must be mindful of the magnitude of the original administrative task. In his opinion, it can be set down as a reasonable rule that under no circumstance should a legislature expect a new plan to go into operation in less than 18 months after its authorization, unless arrangements have been made to utilize an existing administration organization. From the point of view of the insured the virtues of a government plan are mixed. Obviously, some individuals must pay for a basic standard of coverage when they may not want insurance protection at all, or would prefer some other kind. On the other hand, universal coverage makes it feasible to enrol a large number of persons for whom insurance coverage is otherwise unavailable. Moreover, those who consider the standard ward contract of a government plan to be inadequate and who can afford additional premiums are not precluded from purchasing supplementary protection. These are only three of many conclusions set forth by the author in his final chapter.

The Administration of Health Insurance in Canada is an authoritative, informative and very readable book. —W. D. P.

THE OPERATING ROOM SUPERVISOR AT WORK. By Edna A. Prickett, B.S., R.N., Consultant in Operating Room Nursing, Department of Hospital Nursing, National League for Nursing, New York. Pp. 112. Price \$1.50. Published by the National League for Nursing, New York, N.Y.; and co-sponsored by the American Hospital Association, Chicago.

Today's concept of the continuity of patient care requires that the operating room supervisor be a member of the hospital's administrative team, along with the administrator and the director of the nursing service. Today, her ability to lead her fellow workers in getting the work done is as important as her technical skill. Even such general social and economic conditions as changes in employment practices and labour shortages confront today's operating room supervisor and challenge her managerial efforts. Reduction in the work week and increased use of non-professional workers directly affect the staffing pattern which she must devise for the operating room.

This manual was written to assist the operating room supervisor by outlining the organization, administration, and supervision of the nursing service in the operating room. The aim of the manual is to help the operating room supervisor to understand her role as administrative head of the department and to serve as a guide in carrying out her responsibilities. It will also assist operating room nurses who are preparing themselves to advance to the position of operating room supervisor. It provides reference material for college, university, and post-graduate clinical programs, as well as giving hospital administrators, surgeons, directors of nursing service, and other interested persons, a keener appreciation of the operating room supervisor's functions and responsibilities.

ANATOMY FOR THE MEDICAL LIBRARIAN. By Edward T. Thompson, M.D., and Adaline C. Hayden, C.R.L. Pp. 419. Illustrated. Price \$10.00. Published by Physicians' Record Co., Chicago, Ill.

The authors are experts in the field of medical nomenclature and are well known through their *Textbook and Guide to the Standard Nomenclature of Diseases and Operations* which appeared in 1952. This new book may be described as an anatomical introduction to the standard nomenclature of diseases and operations. Anatomical terms, as they occur in the text, are given their proper topographic code numbers; and anatomical parts sketched in the illustrations are likewise marked with their code numbers. A study of this volume will thus at the same time convey an understanding of standard nomenclature. Austin Smith, M.D., Editor, *Journal of the American Medical Association* states, "Their (the authors') objective is commendable, the result of their labour even more so."

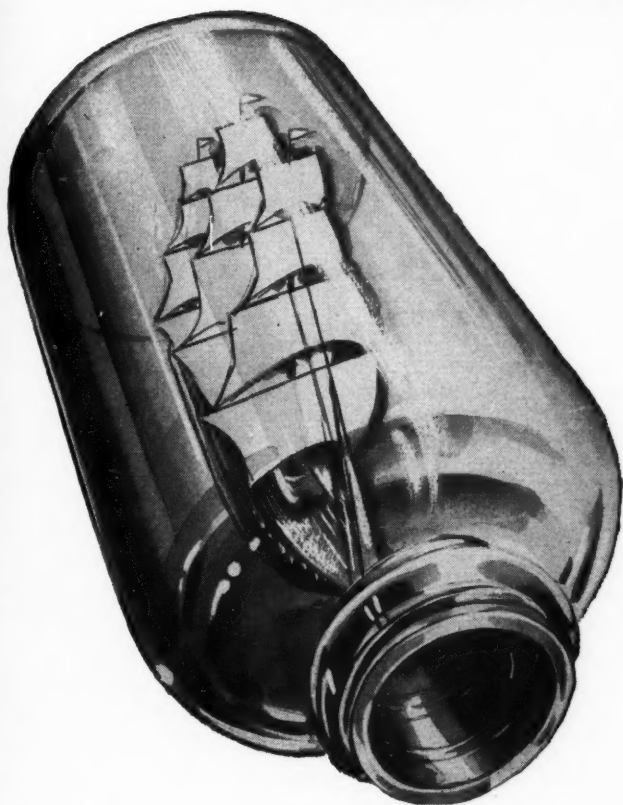
MANUAL ON THE ORGANIZATION AND ADMINISTRATION OF OCCUPATIONAL THERAPY DEPARTMENTS. Compiled by the American Occupational Therapy Association, New York. Pp. 99. Illustrated. Price \$1.95. Published by William C. Brown Company, Dubuque, Iowa.

This manual applies generally recognized principles to problems of the day-to-day operation of an occupational therapy department. To achieve this purpose, the manual has been organized into three parts.

1. Organization: This section outlines the objectives, principles and steps to be undertaken in the estab-

(Concluded on page 86)

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Birthday Celebration

The Ontario Hospital Association marked the 15th birthday of its Blue Cross Plan for Hospital Care on March 17th of this year. Since it commenced operations in 1941, the plan has built its total enrolment up to over two million participants and has provided benefits in excess of \$163,000,000. Blue Cross has become part of the way of life for 40 per cent of the people of Ontario.

The picture shows the cake-cutting ceremony at an "at home" held by the employees of the Ontario Hospital Association to celebrate the Blue Cross birthday. Left to right: David W. Ogilvie, director of the plan; Stanley Martin, associate executive secretary-treasurer, Ontario Hospital Association; J. A. Parnell, general manager, Cunard Steamship Co., Ltd., representing the first group to enrol in the Ontario plan; Dr. G. Harvey Agnew, past president of the O.H.A.; and A. J. Swanson, executive secretary-treasurer, O.H.A.

(Concluded from page 82)

lishment of a department and its overall organization.

2. Administration: Outlines the objectives, principles and specifics of operating a department so as to furnish maximum services to patients.

3. Relationships: This section is purposely extracted from the body of the other two sections and given equal status since the authors consider the essential criterion of successful organization and administration is a development of professional and patient relationships which result in maximum benefits and service to all. The material has been presented under various headings in each of the three parts. Pertinent illustrations are included along with specimen plans and lists. These are given as guides which should be adapted to fit local needs.

A VENTURE FORWARD. A history of the American College of Hospital Administrators. By Ira A. Kipnis, Ph.D. Price \$5.00. Illustrated. Published by the American College of Hospital Administrators, Chicago, Ill.

The story of the book *A Venture Forward* goes back to January, 1952, when a committee was appointed to compile a history of the College of Hospital Administrators and to produce it in some permanent form in which it would be available to members. Ira A. Kipnis, Ph.D., was appointed official historian to study and record in book form the history of this professional society.

The book, as now published, describes the development of the College from its inception years in the early thirties up to 1955. To quote A. C. Kerlikowske, M.D., in his preface, "We now have an account as thrilling as an adventure story of the hospital administrator attaining professional status." Members will be interested to find here pictures of the founding committee, the charter fellows, past presidents, executive secretaries, the first convocation, and the procession at a recent convocation.

The appendix includes charts showing chronological growth records, membership, and fiscal year comparisons. Listed here, too, are officers for each year since 1933, regents, committees, convocations, publications, and educational programs.

A Venture Forward is attractively bound in dark blue linen-finished cloth with the golden key, which is the symbol of the College, impressed upon the cover. It has an artistic format throughout and is printed on excellent stock which makes for ease in reading.

LE SOIN DES MALADES. Rédigé en collaboration à l'Institut Marguerite d'Youville, école supérieure d'infirmières, Montréal. Deuxième édition. 893 pages. Imprimeur, Paul Touchette, Montréal, P.Q., 1955.

Ce volume présente une révision complète de la première édition, parue en 1947. Les nouvelles tendances scientifiques et médicales, en nursing, y sont traitées. Le but en est de donner à la jeune infirmière, une notion juste du

soin des malades, des principes qui doivent la guider, et de toute l'importance de la contribution qu'elle est appelée à fournir, non seulement auprès des malades, mais aussi dans la prévention des maladies et le maintien de la santé publique. Le livre se divise en dix sections et six appendices, contenant des renseignements pratiques que l'infirmière peut consulter à l'occasion. A la fin de chaque chapitre se trouve une liste d'ouvrages choisis pour l'utilité de celles qui désireraient des explications supplémentaires.

LE SOIN DES MALADES. Written by members of the staff of the Marguerite d'Youville nursing school. Second edition. Pp. 893. Published by Paul Touchette, Montreal, P.Q., 1955.

This is the second edition of a book which first appeared in 1947. It discusses the moral satisfaction and the practical skills to be attained through nursing service. New scientific and medical trends are presented in this new edition. Its main purpose is to give an exact idea of nursing duties themselves and the principles which should guide nurses; and to show the importance of the contribution of nurses, not only on behalf of the ill, but in prevention of illness and maintenance of public health. The manual has been written in ten sections each of which gives minute description of the patient care required in various illnesses. Special practical information is given in an appendix and at the end of each chapter is found a list of reference books.

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Here and There

Social Insurance in Austria

A new and comprehensive approach to social security was adopted by the parliament of Austria last September when the General Social Security Act was unanimously passed by all parties. The new act provides practically all employed persons and many classes of the self-employed with insurance against the hazards of illness, old age and occupational injury. The new comprehensive program is financed through the traditional European fund system into which contributions from earnings are paid.

Insurance must ordinarily be taken out for illness, old age, and accident, though groups such as civil servants, for whom government retirement schemes are already in operation, may be insured only for illness and injury, and persons engaged in part-time voluntary work, for accidents alone. Persons who leave covered employment may continue their insurance on a voluntary basis and provision is made for self-employed persons who do not come under the act to insure voluntarily. Dependents of insured persons are also covered and include children to the age of 18, or 24 if at school, children who became permanently disabled before age 18 irrespective of their age and, if there is no wife in the home, any female relative who manages the home without pay.

Hospitalization is provided for periods up to six months, or under certain conditions, a year, with all expenses being paid for the insured and 80 to 90 per cent for dependents. Comprehensive medical care including convalescent care in health resorts or spas is provided through private physicians employed under contract between the Fund and the Medical Associations and by clinics maintained by the Fund. Insured persons may also go to non-contract physicians but in this case reimbursement is made to the patient at the usual Fund rate and he makes his own private arrangements with the physician. Complete maternity care is also supplied. A partial charge is made for prosthetics and for drugs, except that drugs used in treatment of notifiable communicable disease are supplied free. Physicians are reimbursed on a fee-for-service basis.

A sickness allowance equal to 50 per cent of basic wage is paid to the insured after the fourth day of dis-

ability. Lying-in allowance is paid to maternity cases subject to a waiting period and an allowance is made towards death expenses.

The new old age pension is designed so that the average person who has worked for 45 years will receive a retirement income equal to about 80 per cent of his last earnings. It is calculated on the basis of earnings up to \$1,740 per year and increases with the number of yearly contributions made. The salary base on which pension is calculated is the average for the last five years of employment or the five years following age 45, whichever is the greater.

Occupational injury insurance covers a wide range of hazards and provides for complete hospital and other treatment as well as a daily allowance and allowances for dependents. Pensions and allowances for dependents are provided in the case of permanent or temporary disability, and to the widow, orphans, and other dependents in the case of death. Vocational Welfare Institutes assist disabled workers to obtain suitable employment and persons entering new fields of work as a result of disability may be given subsidies or loans to purchase necessary new equipment. — *Canada's Health and Welfare, March 1956.*

Medical Centre for Seoul

A formal agreement to establish a modern national medical centre in Seoul as the joint project of three Scandinavian governments, the Republic of Korea, and the United Nations Korean Reconstruction Agency, was signed in Seoul on March 13th. The medical centre will furnish medical care; provide training for Korean doctors, advanced medical students, nurses and technicians; and serve as a "national institution for the improvement of medical services and elevation of medical standards." The medical centre will be set up at Seoul City Hospital as part of the UNKRA aid program and with contributions from Sweden, Norway, and Denmark. It will receive a maximum of \$11,900,000 in international aid in the construction period and for five additional years.—

United Nations, Department of Public Information.

Study Tour in England

The Central Council for the Care of Cripples will hold its fourth Annual Study Tour from September 16th, to September 23rd. The tour, which will be by motor coach, will cover rehabilitation centres in London, Oxford and Birmingham.

In addition to the opportunity of seeing some of the English services for the disabled, sight-seeing periods will be provided. These will include a visit to Stratford-on-Avon and Warwick Castle. For anyone visiting Europe this summer, this is a rare opportunity to gain an insight into English methods at very little cost. Anyone interested can write either to the Canadian Council for Crippled Children and Adults, 46 Carlton Street, Toronto 2, or directly to the Central Council at 34 Eccleston Square, London, S.W.1.

Singapore's Floating Dispensaries

Malaya's Ministry of Health recently acquired a second "floating dispensary" for the 20,000 inhabitants of the islands around Singapore. The unit, complete with all necessary equipment, is contained in a motor launch named *Seraya* after one of the islands. Total cost of the dispensary was \$94,500. Each one carries a team consisting of a doctor or nursing sister, and a midwife, who undertake maternity and child welfare work.

Ireland's Newest Hospital

A new 286-bed regional hospital was recently opened in Ireland on the outskirts of Limerick. It is a four-storey structure, with an adjoining three-storey wing for out-patients. Included on the grounds is a nurses' residence. The hospital is operated by the Sisters of Mercy.

Down to Earth

In one of the native languages of Australia the Lord's Prayer reads as follows: "Our father on top sky. Thy name is feared. Thou art our boss. Men-women will listen to Thee this place earth as the good souls of men-women listen to Thee on top sky. Give us tucker till the sun goes down. We did wrong; make us good. Watch us against the bad place. Thy hands are stretched out to guard us from bad."

The greatest undeveloped territory in the world lies under your hat.

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Actual clinical tests have indicated an oxygen concentration of 68% at 10 lpm with the Model Twenty-Five Oxygen Tent. Complete separation of blower from the motor permits sealing blower shaft against oxygen loss. There is no intervening ductwork to cause oxygen or temperature loss between cooling chamber and hood.

New, non-cycling refrigeration unit holds temperature inside the hood to within one degree at all times. Humidity is equally stable. The refrigerating unit runs continuously, eliminating "on-off" switching that disturbs the patient and causes temperature variation. Larger, slow-speed blower provides ample circulation at a lower noise level.

Model Twenty-Five is available in three frame heights to accommodate all commercial bed rails. This compact, lightweight unit is mounted on a SterilBrite® frame with 4" ball-bearing conductive casters for greater mobility.

For full details on the Model Twenty-Five, write for Form 2180-OT. If you prefer, ask an Ohio representative to actually show you a Model Twenty-Five Tent



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is designed for simple yet accurate, easy-to-read measurement of oxygen concentration in air-oxygen mixtures. Accuracy of measurement is 2% of full scale. Sturdy, portable, ready for instant use—no special adjustments or calibrations required. For more details, please request Catalog 2180-OT.

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DISPOSABLE HOODS

for oxygen tents eliminate danger of cross-infection, and save the time-consuming task of cleaning and disinfecting. Lightweight, clear .001 plastic hoods have two convenient zipper openings, elastic hanger tabs and nylon draw cord. For more details, please request Catalog 2190-OT.

"Service Is
Ohio Chemical's Most
Important Commodity"

Radiology Dept. (Concluded from page 48)

radiographic facilities for radiologic services during an operation.

On the urological floor, two cystopyelographic suites, each containing two cystoscopic-pyelographic tables, (which are energized by one x-ray generator and control) have been arranged on either side of a fully equipped dark room and wet film viewing room.

In order to further facilitate the examination of patients throughout the new wing, special electrical service lines have been installed on the several patient floors for use in bedside radiography with mobile units.

Records

The diagnostic record room, with pneumatic tube connections to the general offices, patient floors, as well as telephone and "intercom", contains especially designed work desks for the clerical staff in the sorting of patients' films as they come from the dark room, the compilation of radiologic diagnostic dossiers, and the filing of the completed records. Shelf space for approximately five years' accumulation of film files is available. As the individual patient's dossier approaches an age of five years (if the patient has not returned to re-activate his case record), the file is removed from the active library, the films microfilmed, the cut microfilm strip filed with his diagnostic record, and the original films are disposed of, if they are not of particular value as teaching material.

Prior to its move into the new quarters the department had accumulated some 500,000 files. Special mechanically-operated index card cabinets are now installed to take care of the accumulation of the past five years and the future. Other special features provide for the temporary holding, in the active area, of the files on patients who are still in hospital, in order that they may be drawn quickly for reference upon request.

Another special feature, particularly for the convenience of the attending and house staffs of the hospital, is the "long gallery" of staff film-viewing room, equipped with four banks of film illuminators, each of which accommodates sixteen 14 ins. x 17 ins. films, or their equivalent. Each of these banks also may be separated off by folding doors, affording privacy for consultation or for the teaching of small clinical groups of students. This "long gallery" connects with the diagnostic records office by a large counter for procuring dossiers of films.

Opening upon the far end of this

staff film viewing area is the radiologist's "day cabin" where one or more of the attending radiologists, clinical fellows, or resident staff, are constantly in attendance reporting upon cases and available for consultation.

The offices for the several attending radiologists and the resident staff are strategically located in various parts of the department where they may effectively carry on their professional and administrative functions.

Radiation Therapy

The topographic character of the mountain slope, upon which the new wing has been built, has afforded certain advantages in the construction of the radiation therapy section.

A broad spectrum of radiation energy levels has been provided, extending from the "grenz-rays" at 5-10 kv., "contact" therapy at 50 kv., "intermediate" x-ray therapy at 100-140 kv., the "high voltage" group ranging from 0.21 mev. through 0.22 mev. to the 0.28 mev. rotating vanguard unit and the "high energy" Cobalt 60 beam of approximately 1,500 curies at 1.2 mev., together with a stock of radium in various applicators. The several treatment rooms for these are seated in the rock of the mountain at the western end of the department; 12-inch and 30-inch thick concrete walls and ceilings provide protection for the staff and others who might be in contiguous areas above. Special large observation windows of 6-inch, 12-inch or 18-inch thicknesses of laminated plate glass, as appropriate, allow the technical and professional staff to have visual control of patients while under treatment. Further audio control by "intercom" completes the constant contact between each patient and technician.

The Cobalt 60 beam therapy unit in use at the University Hospital, Saskatoon, is suspended from a travelling crane in a 14 ft. x 20 ft. x 15 ft. room at the end of which is a 7 ft. "primary radiation trap" or pit extending further into the mountain. The maximum breadth of the Cobalt 60 gamma exit-beam cannot exceed the margins of this "trap" and the mountain is an effective absorbing medium for protection. This Cobalt 60 room is matched on the southward side by another "high-energy" room for which an 8-10 mev. linear accelerator is now under construction to fill out the spectrum for radiation therapy.

Nearby record, examining, and waiting rooms for the patients of this section permit the radiation therapists to see some 60 to 75 patients daily for their initial visit and clinical examina-

tion, consultation, current treatment or follow up.

Teaching and Research

A conference and seminar room, fully equipped with banks of film illuminators, chalk boards, 8-foot beaded projection screen, radiographic, standard and miniature (2 ins. x 2 ins.) transparency microscopic projector apparatus, seats some 32 persons. This is in use almost constantly for inter- and intradepartmental conferences, graduate seminars and technicians classes. A stainless steel sink and cabinet provide facilities for handling gross pathological specimens. An extensive well-documented roentgenologic teaching file is also housed in this room.

Adjacent to the seminar room is the clinical research room with its own dark room and sink cabinet. This is to be equipped with apparatus which may be built up or taken down and altered readily to suit the project.

Next to this, the radiation physics laboratory, equipped with electronic and other apparatus, is connected with the office of the radiation physicist. This provides opportunity for the members of the staff to develop special apparatus or to service the particular instruments used in the radioactive isotopes section which remains housed in the Ross Memorial Pavilion for private patients.

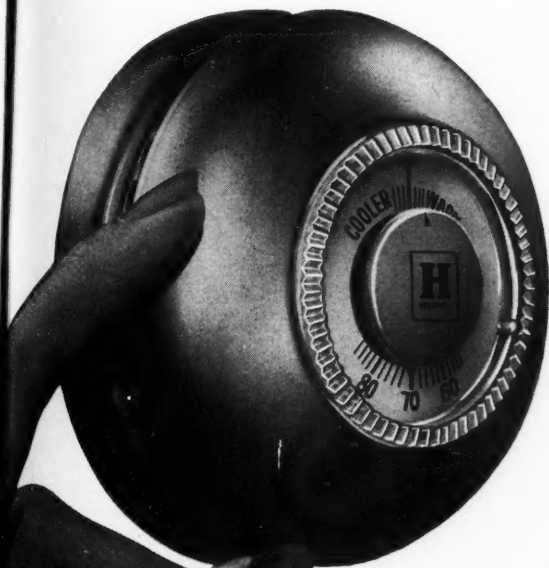
An extensive intercommunication system, for which the patient reception-and-appointment office serves as a hub and message centre, complements the telephone services to selected areas, permitting ready distribution and exchange of information in regard to patients between members of the staff. This facilitates appreciably the flow of patients and saves much time for both professional and non-professional personnel.

The visitor with a special fondness for the traditional green colour of many x-ray departments may have considerable nostalgia here, for yellow, blue, brown, rust, and grey, have been used extensively for the floors, walls or furniture, with only a minor amount of green.

Ant Sense

A golfer who was learning the game teed up and took a mighty swing at the ball. He missed and killed 598 ants. A second swing was unsuccessful and he killed 29 ants. Just as he was addressing the ball for a third swing, two surviving ants held a health conference and one said to the other: "Joe, it looks as though we will have to get on the ball if we want to be safe".—S.H.A. Bulletin.

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For patients' entertainment

A SPECIAL system for the distribution of radio and television programs to individual patients has been installed in the new wing of the Royal Victoria Hospital in Montreal.

Developed by a Canadian electronics firm, the system enables patients to change radio programs at a flick of a finger even when completely immobilized, and allows individual listening to radio broadcasts and recorded music without disturbing other patients in the same room or ward. The development work, resulting in a de-

sign which incorporates the most recent advances in communications engineering, was undertaken by the electronics firm in co-operation with the hospital's consulting engineers in order to meet the specific requirements of the Royal Victoria Hospital.

The hospital, although enviably located from a scenic point of view, had to contend with severe television reception problems. Forward-looking hospital authorities, however, anticipated the need for the distribution of television, in addition to radio pro-

grams, as well as for an announcement system which could also be of great importance in civil defence emergencies. In meeting these requirements, a number of new features not previously incorporated in a communications system of this nature were developed by the engineers. The use of transistorized amplifiers, for instance, is an example of the advanced design methods employed.

The system combines four radio and twelve possible television channels for distribution in a single cable. In addition, the same cable incorporates facilities for announcements and distribution of recorded musical programs. Separate AM, FM, and TV antennae are connected with a central distribution point. Programs are switched on and off through an automatic timing device.

Great care was taken in the design and production of the pillow speakers made available to every patient in the new wing. Enclosed in special plastic material, they can be sterilized by immersion in alcohol or other sterilizing fluids without damage to the delicate receiving mechanisms.

The distribution system adds the final touch to the most up-to-date equipment made available to patients in the new wing of the Royal Victoria Hospital.

Long-Range Planning (Concluded from page 38)

An audiometric room and four rooms with filtered air on the otolaryngology floor.

Our 476-seat cafeteria serves all members of staff and all employees. We closed the seven separate dining-rooms used previously. Meals, except for members of the attending staff, had always been a perquisite and, when we opened the new cafeteria on February 4th, it was found wise to continue that system for the first few days. It is no small feat to start the operation of such a large cafeteria and as might be expected there were waiting lines at first. However, experience soon righted this and waiting lines disappeared. On February 16th we went on a pay basis, with suitable adjustment in salaries. Members of the house staff, student nurses, dietetic interns and medical students living in are excepted. This group was given tickets without charge — a different colour each month — which must be presented at each meal. There is no restriction placed upon ticket holders as to the amount of food they may take

as long as they do not waste it. Everyone carries his tray to and from the table.

The comments we have received from our patients, our staff and our visitors all attest to the fact that the primary objectives of our planning have been attained — in keeping with our re-organized responsibilities to patient care, teaching, research, and community welfare.

Surgery

(Concluded from page 46)

ways sent from the Institute of Pathology, where the tissues are processed, so as to be readily available to the surgeon. A copy of the pathologist's final report on each specimen is also kept on file.

Conference Room. This large, well ventilated room is used for staff conferences and medical and nursing student teaching. It contains the surgical library (temporarily), has blackboards and is equipped with a motion picture projector and screen.

Record Room. The dictated operation reports are transcribed by the operating room secretary and filed in

this room. She also cross-indexes and files the information concerning operative procedures and computes statistics.

Department of Surgery Offices. This suite includes the offices of the surgeon-in-chief, two departmental secretaries and an assistant surgeon, as well as examining rooms and a waiting room. The office of the chief resident on the surgical service is adjacent to that of the surgeon-in-chief. The room is also used for small group conferences and teaching.

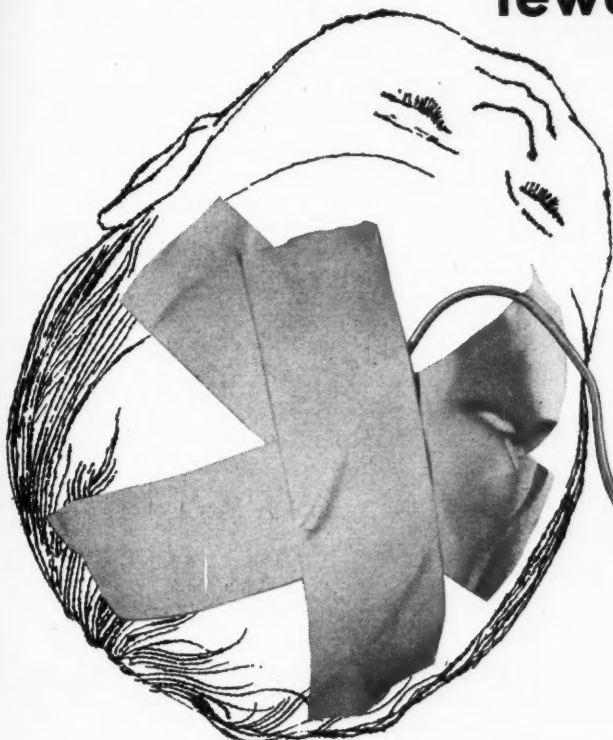
During February, 1956, a total of 670 operations were performed in the new operating room suite. All of these were performed upon hospitalized patients; no outpatients have been admitted to the premises to date. The regular schedule of operations has been almost invariably completed between 8.00 a.m. and 2.00 p.m. and the operating room suite system has functioned very smoothly, to the gratification of all concerned.

Our work is what we are; to do one thing and to be another is impossible.
—Charles Borromeo.

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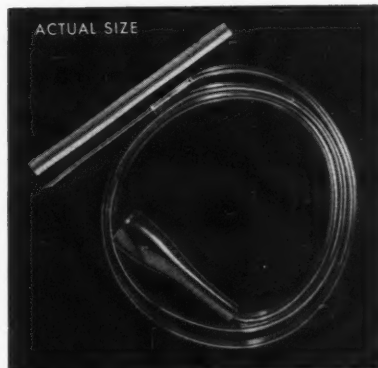
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Award in Hospital Administration

President Sidney E. Smith of the University of Toronto has announced the setting up of an annual award of \$1,000 for the outstanding student in that university's graduate course in hospital administration. This award is to be known as the Robert Wood Johnson Award and has been made available through the generosity of the officers and board of Johnson and Johnson Limited.

The award will be given at the end of the second or residency year and will be conferred upon that member of the class who gives the most promise of making a real contribution towards the advancement of hospitals and hospital administration. Academic standing is to be a criterion although not the sole one. Consideration is to be given to personal attributes — particularly to motivating principles, to capacity for leadership, executive ability, industry, and the ability to give and gain co-operation. The award will be made by the director of the School of Hygiene upon the recommendation of the Department of Hospital Administration.

Commenting upon this announcement, Dr. Harvey Agnew, Professor

of Hospital Administration said: "We are proud of the fine young people who are taking this course and the award will be an added incentive to effort and a fitting reward for work well done".

21st Annual Convention

Canadian Dietetics Association

Members of the Canadian Dietetic Association from all across Canada will gather at the Macdonald Hotel in Edmonton, Alta., for their 21st annual convention on June 26 to 28. A diversified program promises to be most rewarding for those who are able to take time out for this event.

After the opening address of welcome by the president Jean King of Toronto, films taken by the late Lorena Richardson Barfoot will be shown, with commentary by Evelyn Creed, Toronto. One afternoon will feature group meetings: (1) Diet therapy — a panel under Dr. W. C. MacKenzie, Professor of Surgery, University of Alberta, who will speak on "Nutrition of the Surgical Patient"; (2) Administration — Christina M. Robertson, Royal Jubilee Hospital, Victoria, B.C., "Buying China and Cutlery"; (3) Nutrition — Mrs. Winnifred Norquay, In-

dian Health Services, Ottawa, "Food Habits of Northern Indians".

In the course of the various sessions, Dr. Barbara A. McLaren, Department of Household Science, University of Toronto, will speak on "Recent Advances in Nutrition"; and Mrs. Larue Hefaner of Montana State College, Missoula, Montana, will discuss cake mixes. Other subjects to be examined are: atomic energy in medicine; keys to management; and personnel policies. A practical demonstration on choosing and cutting beef is to be given by the representative of a commercial firm.

This year, at its annual banquet, the Canadian Dietetics Association celebrates its 21st birthday and for this occasion members will be the guests of the government of the province of Alberta, with Dr. W. H. Johns, Dean of Arts and Sciences, University of Alberta, as guest speaker. Another special event on the program is the Memorial Lecture of the Violet Ryley — Kathleen Jeffs Foundation which is to be presented by Dr. E. P. Scarlett, Chancellor, University of Alberta.

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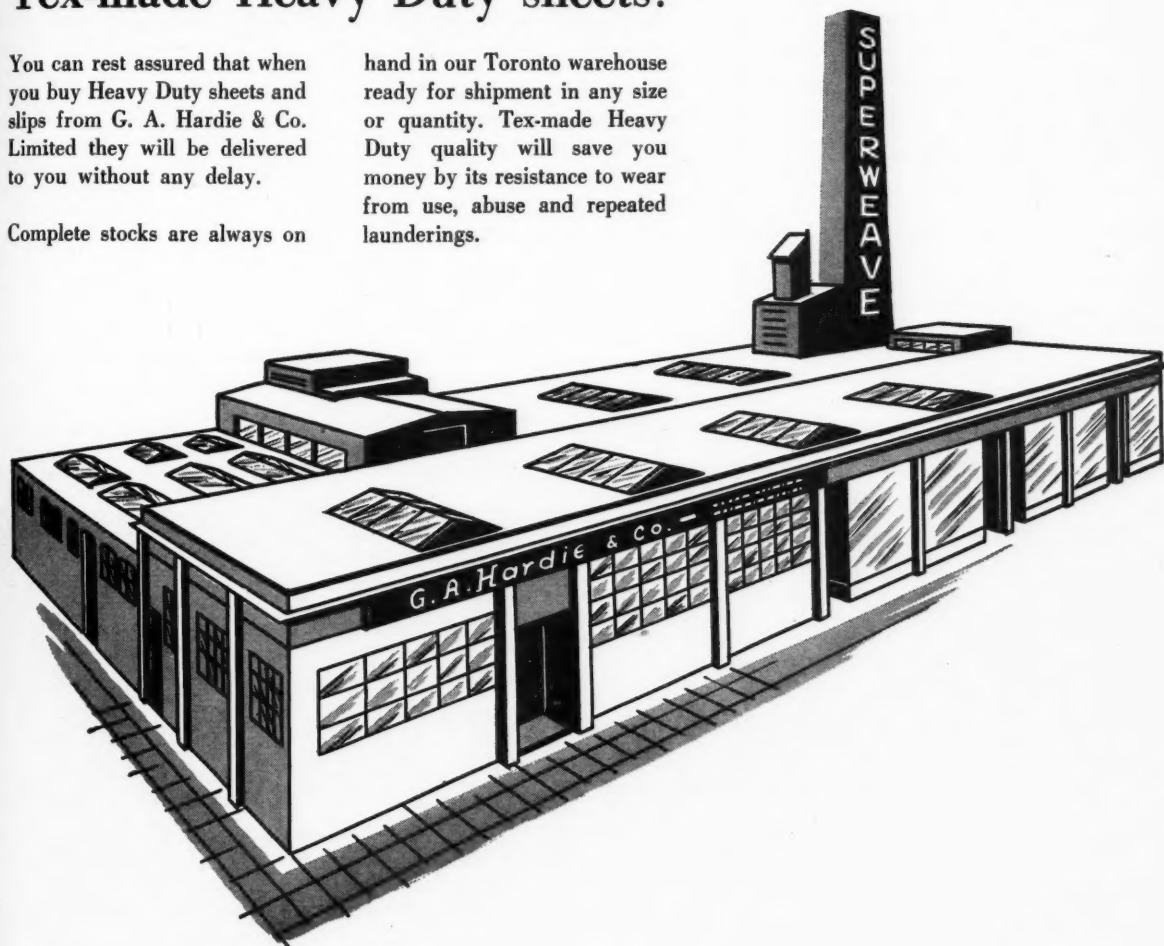
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A.C.S. Approves Hospital Cancer Programs

A properly functioning registry of cancer patients is a requirement for approval of a hospital's cancer program by the American College of Surgeons, under new regulations which are now effective. The College program considers a hospital's cancer activities only; and is entirely separate from the Joint Commission on Accreditation of Hospitals, which accredits hospitals on the basis of detailed studies of medical and administrative activities.

In a new manual for hospital cancer programs, the College's Department of Professional Services and Accreditation has set forth the minimum requirements for approval of a cancer program. The requirements recognize three types of cancer program. These are:

1. The specialized cancer hospital providing complete service for cancer patients.

2. The general hospital conducting organized cancer clinical activities, including cancer registry, cancer consultation and treatment service.

3. The general hospital, usually small in size, which maintains only a registry of all cancer patients.

All three types of program must be under the supervision of a cancer committee of the hospital's medical staff consisting of physicians directly concerned with the diagnosis and treatment of cancer and appointed by regularly established medical staff authorities. To quote Dr. James B. Mason, director of the Department of Professional Services and Accreditation of the College, in a recent release: "The duties of this committee shall be to initiate, supervise and continually appraise the cancer programs and to report to the medical staff at least once annually."

The purpose of a registry is to maintain a continuing record of successes and failures in the management of cancer patients in every hospital seriously concerned with the treatment of this disease, Dr. Mason explained. Reports are to be made regularly to the members of the hospital medical staff, so that they are repeatedly ap-

prised of their individual and collective rates of success, thus allowing comparison with other institutions and pointing out weak spots where "shorting up" is needed. The minimum content of the cancer registry was described as including the name and address of every patient upon whom a diagnosis of cancer is or has been previously made, with adequate identifying and diagnostic information and an abstract of the clinical record. Annual follow-up notes must be maintained as long as the patient remains alive, it is stipulated. "From this minimum base, the content of the cancer registry may be elaborated as far as those conducting the program may desire," Dr. Mason said.

College requirements also specify procedures for maintaining the registry, including proper methods for obtaining the complete roster of patients with cancer, methods for adding new cases as they occur, and methods of developing the case abstract file.

The College cancer program also includes detailed requirements for the complete cancer hospital; and for general hospitals maintaining cancer consultation services and cancer treatment



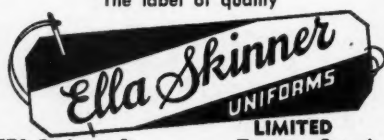
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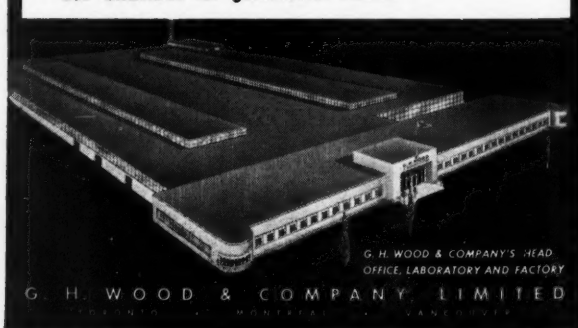
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services. Hospitals of all three types must submit reports, at least annually, showing the results obtained with cancer patients and including five-year results as these become available through continuing follow-up. The College surveys hospitals and cancer clinics regularly to make certain standards are maintained; this program is supported jointly by the College, the National Cancer Institute, and the American Cancer Society.

The same release from the College quotes Dr. Danely P. Slaughter, Associate Professor of Surgery at the University of Illinois College of Medicine and Chairman of the College Committee on Cancer: "Because of growing interest in the constantly increasing cancer problem, active educational programs on cancer are being carried on in a large number of hospitals in the United States and Canada. In the individual hospitals evaluation studies are prepared from material accumulated in the registry; formal conferences and seminars are held; material is obtained for clinical-pathological conferences; increasing numbers of clinical sessions are open to all physicians of the hospital staff and of the community and surrounding area.

"These activities are resulting in constant improvement of the type of care offered cancer patients in hospitals everywhere. The cancer program of the American College of Surgeons is aimed at improving the treatment of cancer patients, as well as cancer education of physicians. It is hoped that other hospitals not now having organized cancer facilities will be encouraged to start registries and maintain individual follow-up records, keeping their own current 'box scores' of cancer results."

Two-year Training Course at Glasgow Royal Infirmary

An experimental course of training for student nurses is to begin in Glasgow Royal Infirmary in September of this year. Formal study will be concentrated into a period of two years—instead of three as at present—the third being devoted entirely to practical experience in the hospital; and the aim is to develop qualities of leadership and judgment. The course is to be suitable for university graduates and for girls with a good higher leaving certificate or other educational qualification, between 18 and 25 years of age.

Graduates of the course can expect

rapid promotion (within two or three years of qualifying) to ward sister, with a salary scale rising to £575 a year. Promotion to higher posts beyond this can also be expected at a comparatively early age. There will be no fees for the course and the usual training allowances for student nurses will be paid.—*The Hospital*, March, 1956.

Rehabilitation Unit for Essex County

In Windsor, Ontario, the Institute of Physical Medicine and Rehabilitation of Essex County was officially opened by the Honourable L. P. Cecile, provincial Minister of Welfare. After praising the spirit of co-operation which had resulted in the formation of the Institute, Mr. Cecile went on to outline the province's program of allowances for handicapped individuals undergoing training. The allowances will range from \$60 to \$115 per month.

The task of psychiatry in rehabilitation consists in having the person disengage his attention from the focal point of disability and to visualize himself again as a whole person with right aspirations, duties and potentialities. —*Dr. Roger Lemieux, Prof. of Psychiatry, University of Montreal.*

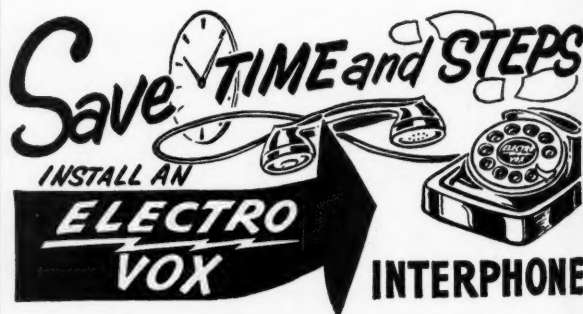
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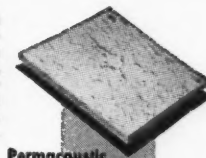
ings can be installed over the old ceiling—with exceptionally attractive effects decoratively, as well as remarkable changes acoustically. There are J-M Acoustical Materials for every specific requirement and every budget. For expert acoustical advice on a specific problem, or for our free book "Sound Control", write Canadian Johns-Manville, 565 Lakeshore Road East, Port Credit, Ontario.

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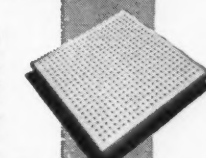


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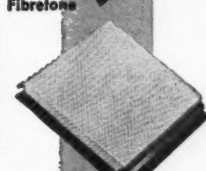
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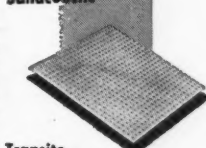
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Twenty Years Ago

("The Canadian Hospital, May, 1936)

The much discussed compulsory health insurance bill (British Columbia) has finally received its third reading. However it will not become operative until formally promulgated. Among salient features of the new act are these: Compulsory health insurance for employees receiving \$1,800 per annum or less; voluntary contributors other than employees may be enrolled; benefits shall include (1) medical care for prevention, diagnosis and treatment, including maternity, surgical and specialist care and (2) hospitaliza-

tion in a public ward, including all services provided by the hospital, for ten consecutive weeks in any one illness . . .

The small Royal Hospital at Barkerville in the Cariboo district, some 40 miles east of Quesnel, B.C., was destroyed by fire on March 29th. There were no patients in the hospital at the time and Helen Olsen, the matron, escaped without injury from her living quarters on the second floor.

The Hamilton (Ont.) Board of Control has decided not to accede to a request to open the Mount Hamilton Maternity Hospital, completed in 1932

at a cost of \$800,000 but never used. This beautiful building provides only for the more expensive private ward accommodation and an immediate outlay of some \$45,000 for further equipment would be required if the building were opened. The maternity hospital could only be operated under a \$20,000 deficit, it is claimed.

Early in April the little 18-bed Anglican hospital at Aklavik, N.W.T., was burned to the ground. How much of the equipment was saved is not known but the loss is estimated at approximately \$25,000. The destruction of this hospital will be a serious blow to the population of a far northern area, although it is presumed that temporary quarters will be set up for emergency work. Aklavik is 1,600 miles north of any railway.

A large public meeting was held in Prince Albert on April 24th, with a capacity house. During the meeting a Saskatchewan State Hospital and Medical League was organized and officers elected, the object being to institute a campaign for the socialization of the medical structure of Saskatchewan. While it was admitted that the cost of the socialization of medical services was terrifically high, it was thought that the levying of taxes for such an objective would be popularly received.

At its annual meeting the Royal Inland Hospital (Kamloops, B.C.) reported a successful year, due mainly to the group hospitalization plan which now has some 1,600 subscribers. In the past two years, the board has paid off \$10,000 in old debts, although when the plan was started the hospital was faced with the prospect of closing its doors through financial difficulties.

A hospital association has been organized in the seaport town of Liverpool, N.S. Plans are being developed for the holding of a financial drive to raise funds for a local hospital.

Citizens of the small community of Fairy Glen, Sask., met recently and organized the Fairy Glen Community Hospital Association for the purpose of sponsoring the erection of a 4-bed nursing home. The site has been donated.

Captain J. E. Stone, secretary of the Birmingham Hospitals Council (Birmingham, Eng.) and author of several widely-known textbooks on hospital administration and allied subjects, has been elected president of the British Magical Society, the oldest society of the kind in Great Britain. It is said that Captain Stone uses his ability as a conjurer to assist in raising funds for hospitals.

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by **Norman D. Bailey, B.A., M. Ed.**

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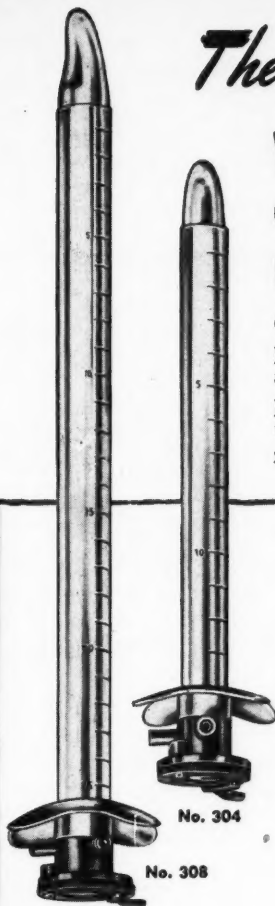
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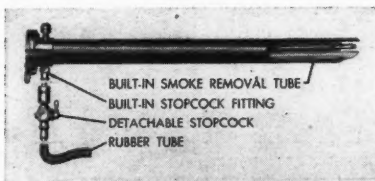
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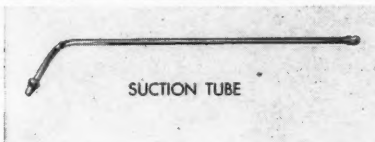
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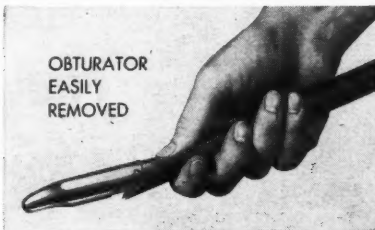
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(Continued from page 72)

date of meeting was set at March 21.

Although we remain inadequately informed regarding the National Hospital Plan offered by the Canadian Government to the provinces that are willing to share the cost in the proportion of 50 per cent, it is realized that the hospitals will be called upon and they will fulfil an important mission in that connection. We have, therefore, offered our full co-operation to the Minister of Health in the study of this vast problem — the distribution of medico-hospital care. Mr. Paquette being absent, his secretary assured us that our letter would be submitted to the Honourable Minister as soon as he returned to his office.

Last year, during April, in pursuance of the initiative taken by our Council, an institute for the benefit of the French-speaking delegates from our hospitals was organized by Notre-Dame hospital. The principal topic considered was civil defence in the event of disaster. Delegates from 42 hospitals attended. Successful discussion was enhanced by the presence of distinguished persons such as Mgr. Olivier Maurault, Rector of the Uni-

versity of Montreal, Honourable Paul Martin, Minister of National Health and Welfare, His Honour Mayor Jean Drapeau, and representatives of the provincial government. A realistic simulated disaster merited high praise for its organizers. Hôpital du Christ-Roi, of Nicolet, submitted a fully detailed defence plan. The officials of Notre-Dame Hospital, and in particular its executive director, Doctor Paul Bourgeois, deserve our sincere congratulations on the success of this enterprise.

In connection with extension services of the University of Montreal, a three-day institute was called last year for the French-speaking delegates of our hospitals. The theme of this institute was "Legal Problems in our Hospitals". Lectures were delivered by judges, lawyers, doctors and others. These were much appreciated by the 152 registered delegates. This, incidentally, was the highest recorded attendance to date for any of the institutes organized by our Council. His Eminence Cardinal Léger, despite his numerous occupations, honoured us by his presence at one of the meetings when he spoke to the delegates assembled at the University of Montreal.

We are indebted to Doctor G rald

LaSalle, our Secretary-General, for the organization of this institute which received praise from everywhere in the province. In compliance with requests from widely scattered sources, another institute on the same subject is to be held shortly to discuss further and clarify certain matters which were not considered previously.

In co-operation with the Deans of the Faculties of Law and Medicine of McGill University and of the University of Montreal, similar institutes for English speaking and French-speaking delegates have been arranged for this year.

In order to uphold the reputation of our members who had recently been subjected to unfair criticism by certain newspapers, it was decided by our Council to carry on a campaign for the benefit and education of the press and general public, to make them aware of the difficulties of all sorts encountered by our hospitals in the performance of their humanitarian work.

At the beginning of this campaign, the Executive Committee of our Council convened representatives of Montreal daily newspapers to exchange views on various questions. Following



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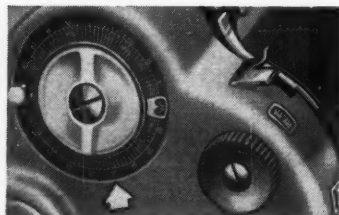
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(Concluded from page 108)

upon friendly discussion, it was decided to adopt a code to be used by the hospitals to convey information to the press. This code was drawn up by legal counsel and copies were sent to the hospitals and newspapers. It is hoped in this manner to promote better understanding in press relations. We propose also to study these regulations more fully in the course of future meetings.

For many years, our Council has advocated an association to include all the hospitals in the province but endeavours to that end have until now proved fruitless. It is a well-known fact that Quebec hospitals are grouped into five different associations, which effectively divides their efforts and lessens their prestige when dealing with provincial and other authorities. However, I am now in a position to inform you that during recent weeks a new movement has taken shape with the approval of the authorities and, therefore, it is hoped to group into one strong association all the hospitals of the province. This project is viewed favourably by all those concerned and its realization will certainly be epoch-making in the annals of hospital history.

It is with pleasure that we congratulate the University of Montreal for its initiative in the founding of a School of Hospital Administration which should prove to be of great benefit to those who plan a career in this field of endeavour.

Congratulations are in order to Doctor G  rald LaSalle, our Secretary-General, for advocating this school and persuading the authorities to establish it. •

Fish Flour Bread

Canadians may soon be tasting fish flour bread. Dr. Henry Foug  re, chief scientist at the Atlantic Fisheries Experimental Station, Halifax, N.S., reported in January to the annual meeting of the Fisheries Research Council that his staff has already produced experimental loaves of bread—of good appearance and taste — from flour mixed with fish protein meal manufactured from the products of Canada's coastal waters. Dr. Foug  re reports that the new fish protein product is white, odourless, and tasteless, and appears satisfactory when combined in amounts up to 20 per cent of the total flour in the experimental bread formulae. — *Consumer Information.*

In this life, if you have anything to pardon, pardon quickly. Slow forgiveness is little better than no forgiveness.—*Sir Arthur W. Pinero*



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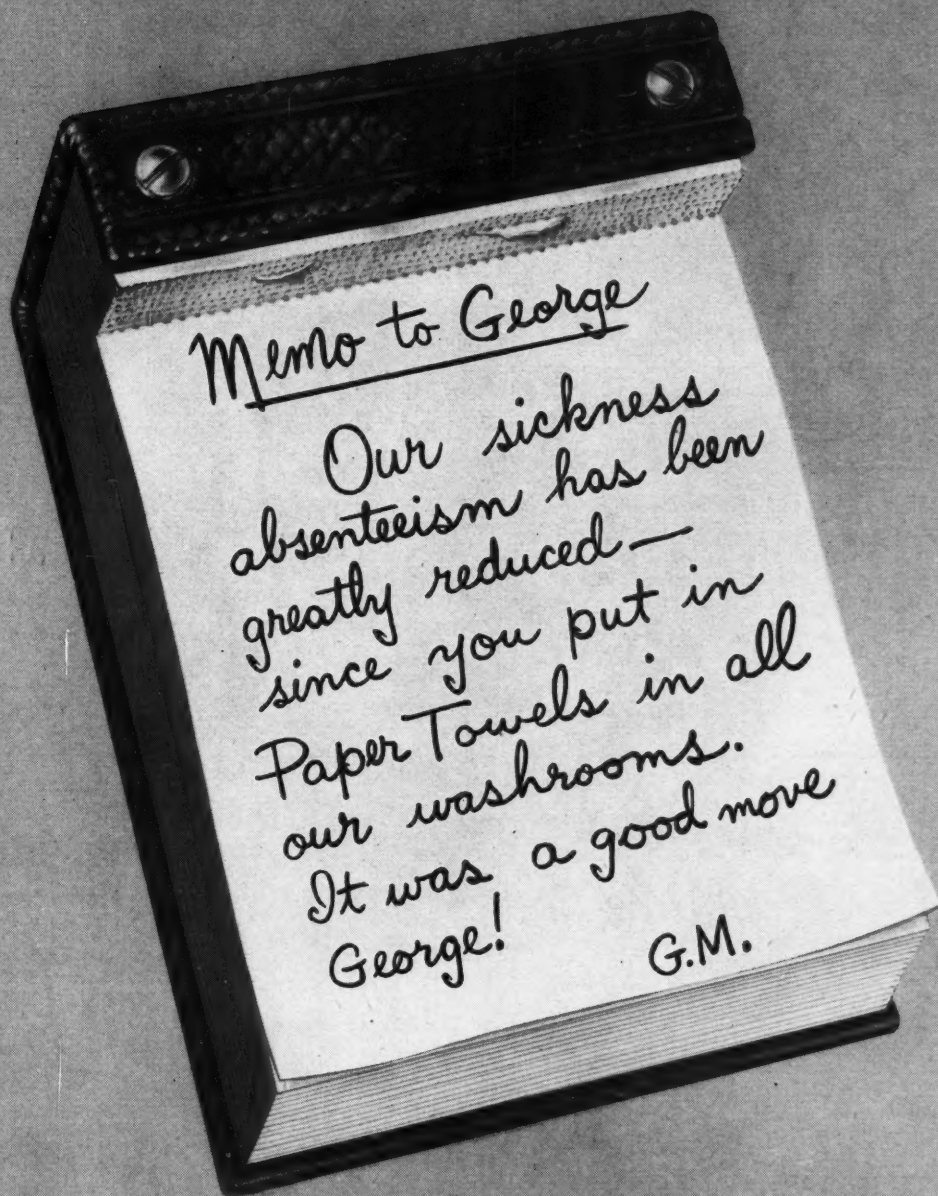
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Notes About People (Concluded from page 22)

ville, Ont. A graduate of the University of Toronto, Miss Klein holds the degree of bachelor of science in nursing. Her experience has been with the Victorian Order of Nurses and the Red Cross Outpost Service.

• In honour of May Trueman, R.N., who retired recently as superintendent of Highland View Hospital, Amherst, N.S., a reception was held in the nurses' home of the hospital. The function was under the auspices of the hospital commission, the Ladies' Aid, the hospital and medical staffs; and many fine gifts were presented in appreciation of Miss Trueman's services.

• A West Vancouver resident has been chosen head of the board of trustees of the North Vancouver Hospital. The new chairman is John Richardson, reeve of West Vancouver, B.C.

• Mrs. Glenn Allan, matron of Grand Forks Community Hospital, Grand Forks, B.C., for the past two years, has resigned from that post. Helen Campbell has been named acting matron, pending the appointment of a successor to Mrs. Allan.

• Dr. P. Noel Murphy, who arrived in Saint John, N.B. from Ireland recently, has assumed his duties as resident physician at St. Joseph's Hospital there. Dr. Murphy is a graduate of the National University of Ireland and has held staff positions at hospitals in Coventry and West Bromwich.

• On the staff of Toronto Western Hospital since her graduation in 1919, Mary Thomas, R.N., was guest of honour at a tea and presentation upon her retirement a few weeks ago. For the past four years, Miss Thomas had held the post of operating room department administration supervisor.

• Mary A. Jones, seamstress at the Royal Inland Hospital, Kamloops, B.C., for 38 years, was honoured by a tea and many gifts on the occasion of her retirement. She was also granted a month's leave with pay in recognition of her long years of service.

• Mrs. Josephine Kelly of Nanaimo, B.C., has been appointed superintendent of nurses at Prince Rupert General Hospital, Prince Rupert, B.C., according to an announcement by the board. She succeeds Elizabeth Clement, R.N.

• At the annual meeting of the Cobourg District General Hospital, Cobourg, Ont., directors accepted with regret the resignation of A. C. Hodgetts as president and chairman. R. G. Parker was appointed to replace him.

• Dr. Antoine Valois of Verdun, P.Q., has been appointed assistant to Dr. Adelard Groulx, head of the Department of Health, Montreal, P.Q.

• For the ninth term, Kenneth W. Ingersoll has been elected chairman of the board of directors of the Grand Manan Hospital, North Head, Grand Manan, N.B.

• Dr. Robert T. Noble, registrar of the College of Physicians and Surgeons of Ontario for the past 17 years, has announced his retirement. He will be succeeded by Dr. Harris McPhedran, Toronto.

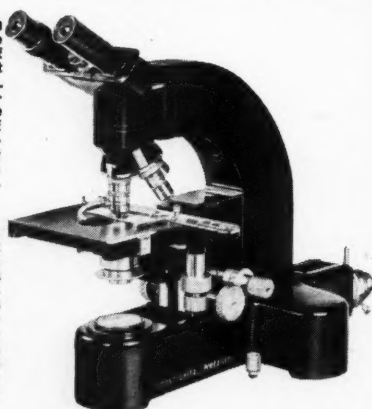
• H. W. Solomon will head the Meaford General Hospital (Meaford, Ont.) board of directors for the coming year. He was named chairman at a recent annual election of officers.

What really flatters a man is that you think him worth flattering. — G. B. Shaw

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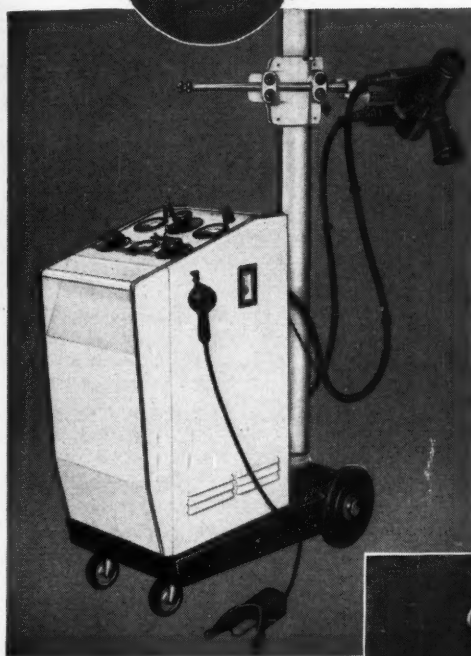
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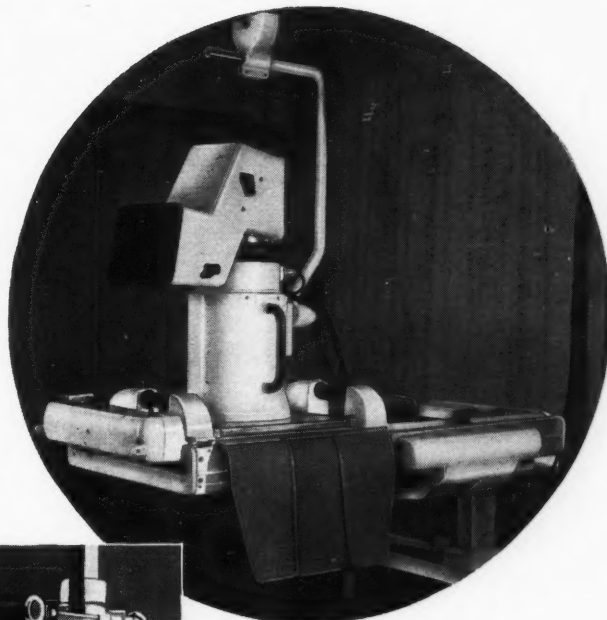
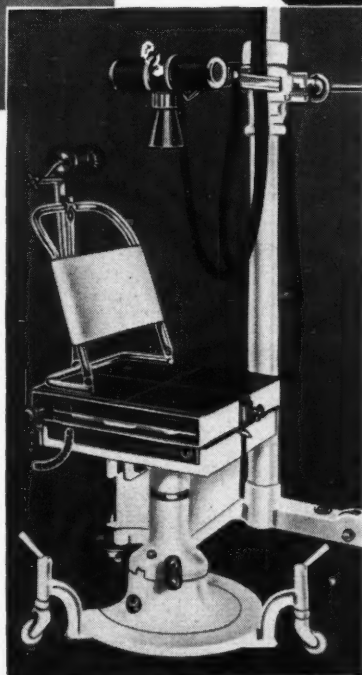


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New Home for Food and Drug Directorate

The staff of the Food and Drug Directorate of the Department of National Health and Welfare, Ottawa, now occupies a new building at Tunney's Pasture, a former field beautifully located on the Ottawa River and now being used for permanent government buildings. Since the Food and Drug Directorate has administrative as well as research and analytical functions, the building has an administrative wing as well as a chemical laboratory and a biological wing.

The laboratory wing forms the largest part of the building and provides modern facilities for work in organic chemistry, food chemistry, nutrition, biometrics, microbiology, pharmacology, physiology, animal pathology, biophysics and pharmaceutical chemistry. The wing contains a seminar room for discussions by the scientific staff, a store room, a shipping and receiving room, a staff room and a workshop where repairs to equipment and laboratory fixtures can be made. The laboratory contains specially designed rooms for working in low temperatures and in the dark. There are also refrigeration rooms for storage at different temperatures.

The biological wing attached to the laboratory wing is air-conditioned throughout and will house the colony of white rats and mice, guinea pigs and other biological material used in determining the safety of foods and drugs and the potency of medicines. The construction of the building is reinforced concrete and brick and in appearance it conforms in general design to other buildings in Tunney's Pasture. Its cost was \$2,566,450. — *Canada's Health and Welfare, February, 1956.*

Greenwich Mean Time Moves to Haunted Castle

Wayback in 1675 King Charles II founded Britain's Royal Observatory in the little rural village of Greenwich, outside London. Over the years Greenwich became a very famous spot, for in 1884 an international conference held in Washington, D.C., established that the world's prime meridian passed directly through it. It also established the world's time zone system and de-

signed Greenwich as the long point of departure for the world's maps and chronometers.

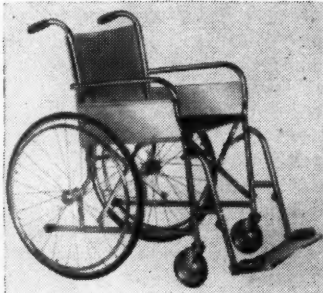
Since then "Greenwich Mean Time" has become a phrase known the world over, and even behind the Iron Curtain it is accepted.

Now, after 280 years, the Greenwich Observatory has moved its location. The one-time country village is now a part of smoky, foggy London, and Britain's Astronomer Royal, Sir Harold Spencer Jones, and his staff have moved to Herstmonceux Castle, 60 miles away in rural Sussex, where a view of the sky is unobscured by "smog".

The change has required the subtraction of a minute and a quarter from observed time at Greenwich as longitude is now 20 minutes and 25 seconds east of the Greenwich meridian and latitude is 36 minutes and 30 seconds south of the Greenwich parallel of latitude.

The 15th century castle has been remodelled inside to accommodate Sir Harold and his people, but it is still reputed to harbour the ghost of a girl, murdered generations ago. — *Flight Horizons, T.C.A.*

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V.O.N. in Post-Hospital Care

A liaison with the Victorian Order of Nurses has recently been established at the Montreal General Hospital. A representative from the V.O.N. confers regularly with doctors, nurses and social workers in the hospital, to discover cases which are appropriate for follow-up V.O.N. care. This "after-hospital" program is designed to ensure that the home supervision of the patient during the convalescent period is satisfactory and that the patient receives the kind of post-hospital care which will best assist recovery.

A liaison has also been established between the V.O.N. and the School of Nursing. As part of their regular training course, students spend a week with V.O.N. nurses, acting as observers while the nurses make their rounds in the city. In this way, students are given an increased understanding of what it means to a family to have a patient to care for at home. The differences between home and hospital care are clearly pointed up during the home visits. It is the opinion of the school that this experience, with the increased awareness it brings of the

many implications of illness, is an invaluable addition to the training course for nurses at the hospital. — *Women's Auxiliary News Letter, M.G.H.*

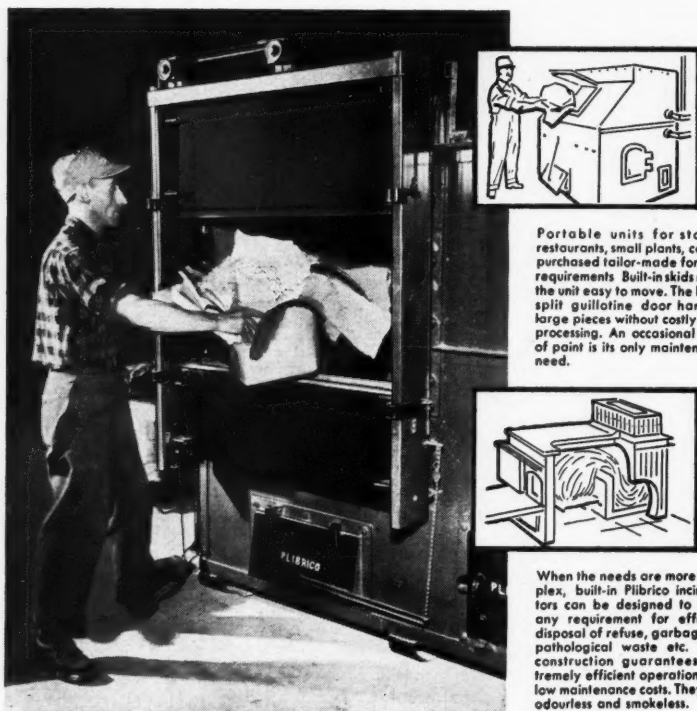
Increased Longevity

A baby girl at birth may expect to live longer — up to about 6-7 years longer in some countries — than a baby boy in all 61 countries covered by tables in the *United Nations Statistical Year Book* except in Ceylon, India and among the Asian population of the Union of South Africa. According to the latest post-war data, a baby girl at birth may expect to live longest in the following countries (corresponding figures for a baby boy in parentheses): Netherlands 72.9 years (70.6 years); United States (white population) 72.7 years (66.6 years); Norway 72.7 years (69.2 years); England and Wales 72.4 years (67.3 years); New Zealand (excl. Maoris) 72.4 years (68.3 years); Sweden 71.6 years (69.0 years); Canada 70.8 years (66.3 years); Australia 70.6 years (66.1); Scotland 70.5 years (65.5); Israel 70.5 years (67.5); and Denmark 70.1 years (67.9).

Among countries which have the longest life expectancy for both sexes, the difference in the average life span of a baby girl and a baby boy — in favour of the former — ranges from 2.3 years in Denmark and the Netherlands up to 6.1 years in the United States. The order of the countries is also different for male babies, except in the Netherlands, and very noticeably so for the United States which ranks 2nd for female life expectancy at birth but only 8th for male life expectancy.

Since the 1920's the average length of life expectancy at birth has been substantially increased in all the countries included in the Yearbook Table, particularly in the less developed countries, as the result of improved living conditions and medical care, and the consequent decline in infant mortality. For example, the life expectancy of a baby boy at birth has been extended by 24.9 years in Ceylon (1920-22 to 1952); by 19.8 years in Jamaica (1920-22 to 1950-52); by 18.7 years in Trinidad (1920-22 to 1950-52); by 15.9 years in British Guiana (1920-22 to 1945-47); by 11.7 years in England and Wales (1920-22 to 1953); and by 11.4 years in France (1920-23 to 1950-51).

The man who has not anything to boast of but his illustrious ancestors is like a potato — the only good belonging to him is underground. — *Sir Thomas Overbury.*



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Eskimos Get Training During Treatment

The Eskimos' written language is a kind of shorthand. Over 80 per cent of the Eskimo patients who arrive at Mountain Sanatorium, Hamilton, have learned it from missionaries. That is why *Mountain View*, the patient's magazine at the Mountain Sanatorium, is publishing articles in Eskimo syllabics. They also publish some material in Cree syllabics. English translations are included for English speaking patients.

Publishing some of the magazine in Cree and Eskimo syllabics is just part of a sustained program designed to go half way (or more where possible) to meet the needs of 260 Eskimos and 40 Indians while they are being treated in Mountain Sanatorium. The first objective will be to give patients basic English starting with speaking and going on as soon as possible to reading and writing. Elementary arithmetic follows.

But teaching reading, writing and arithmetic in English is only half the story. They have to teach Eskimo, too, or see that the patients do. Among those coming in from the Arctic are a good many children so young that they could easily lose their mother tongue unless a sustained effort were made to keep them familiar with it. This is to be avoided, for nobody wants them to return home as strangers. Consequently another sizeable effort in organization is necessary — finding foster parents within the sanatorium to keep the children in touch with home. — *Bulletin, Canadian Tuberculosis Association.*

Epilepsy Association Chartered

Granting of a charter for the Ontario Epilepsy Association recently culminated the work of small groups interested in epilepsy during the past four years. The organization is de-

voted to epilepsy research and to provision of treatment and assistance for the 20,000 known sufferers from the disease in Ontario. Public support is called upon to bring medical, physical and moral help to these victims and to work toward eventual elimination of epilepsy as a scourge.

\$350,000 Gift of C. L. Burton to Further Liberal Education

C. L. Burton of Toronto has personally contributed 20,000 shares in the company of which he is chairman, to be divided equally among four separate trusts. Beneficiaries are the Ontario Heart Association, Women's College Hospital and St. Michael's College. The fourth trust is divided into two parts, one for scholarships in the humanities at University College, the other to augment a fellowship fund which he had earlier established in memory of his brother, the late E. F. Burton, former director of the University of Toronto's physics laboratory. The gift to Women's College Hospital is intended to help young women doctors become established, in research, postgraduate work, or in general practice.

Freeze that Bread!

It may well be that institutions will soon be cutting down on food costs in a new way — by freezing their bread. Research conducted by the United States Department of Agriculture and the Refrigeration Research Foundation indicates that, whether institutions bake their own or buy from bakeries, the freezing process may prove to be a real economy measure. For hospitals, of course, its most obvious result would be reduction of staling and waste of left-over bread. Findings of the research project show that bread is best when frozen as rapidly as possible after baking. — *"Institutions Magazine," February, 1956.*

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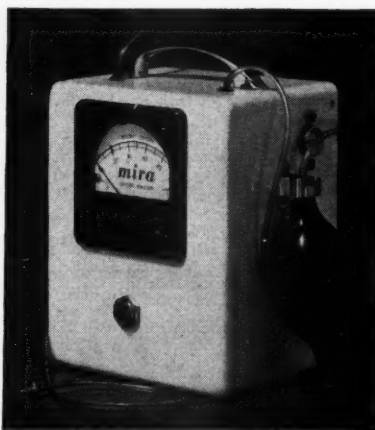
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Research into the problem of retroleental fibroplasia in infants seems so far to be inconclusive as to basic causes. It has been suggested, however, that among other precautions, oxygen be prescribed and measured in concentrations rather than flow rates. Also, for this purpose, that oxygen analyzers be made standard equipment in nurseries.

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C.M.A. Art Salon

The Physicians Art Salon Committee of the Canadian Medical Association invites any Canadian physician or medical undergraduate to enter his or her work in the 1956 Salon to be held in the Chateau Frontenac, Quebec City, from June 11th to 15th. This will be the 12th year in which the popular art and photographic feature of the C.M.A. annual convention has been held. It is sponsored by Frank W. Horner Limited, Montreal. An entry form, with detailed information, may be obtained by writing to the sponsor at P.O. Box 959, Montreal.

A Place for Everything (From the Bulletin of University Hospital, Saskatoon)

Last week we discovered that a certain can opener was missing. A can opener is a very minor piece of equipment as far as expense is concerned, but a very major piece of equipment when one wishes to open a can. This has not been the first time that we have counted to ten with can in hand, while looking for the can opener.

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Equipment is placed in certain areas for certain purposes and is meant to be used there. If it is necessary for the equipment to be absent from its designated spot, it should be replaced in minutes, not days or weeks.

How much time is wasted by individuals at work or at home trying to locate equipment which is not where it should be? How many people are inconvenienced when the pencil sharpener or the floor mop or the telephone pad suddenly disappear? It means the floor cleaner is looking through all the cleaning cupboards in search of a mop, the clerk is going to the office upstairs to sharpen her pencil and the wall beside the telephone looks like a small child's attempt to paint a mural in the hall.

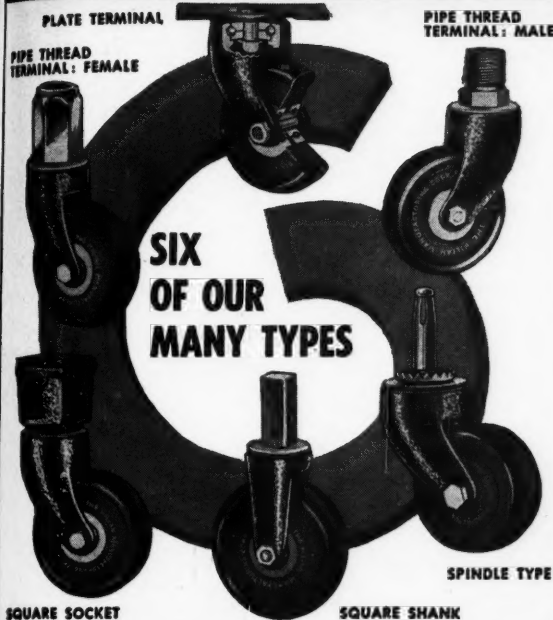
Replacing articles where you found them results in greater efficiency, less time wasted, better personal relations (fewer frayed tempers) and greater economy (fewer replacements needed).

It has been our experience that it takes one person approximately two hours of intense research to locate misplaced equipment if one has to constitute a thorough search, that is, phoning all persons who may or may not be concerned but who might have a clue for you, writing numerous requisitions, accusing all persons seen, and searching every nook and corner personally with a flashlight.

Incidentally, has anyone seen our can opener?

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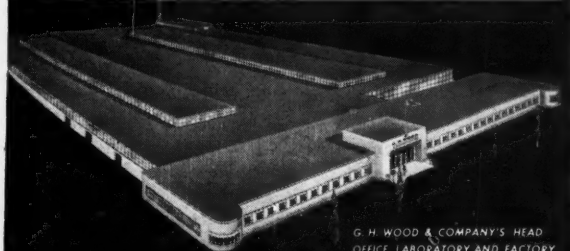
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120 bed hospital, fully accredited. Qualified hospital administrator preferred. Apply stating qualifications, age, salary expected and date available. Closing date for applications, June 6, 1956. Address, R. F. May, Q.C., Northwestern General Hospital, 2175 Keele Street, Toronto 9, Ontario.

Director of Nursing

QUEEN ALEXANDRA SOLARIUM FOR CRIPPLED CHILDREN, VANCOUVER ISLAND, B.C. Applications are invited for the appointment of DIRECTOR OF NURSING for this 50 bed, long stay children's hospital, situated by the water at Mill Bay near Victoria. The Hospital is fully Accredited and plans are almost complete for relocating and rebuilding the hospital which will be situated by the water at Finnetty Bay in Victoria within the next twelve months. The new hospital will be increased in size to 64 and then 96 beds. A very modern suite is available. Successful applicant will be required to register in B.C. Forms of application may be obtained from Administrator, Queen Alexandra Solarium for Crippled Children, Cobble Hill P.O., Vancouver Island, B.C.

Position Desired

Trained Hospital Administrator wishes to relocate anywhere in Canada. Presently in charge of 200 bed teaching hospital. Will consider smaller or assistant position. Qualifications and references immediately available. Please write Box 519S, The Canadian Hospital, 57 Bloor St. West, Toronto.

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Accountant-Office Manager. Former Deputy Finance Officer in English Group of Hospitals with experience of mechanized accounting requires position in Canadian Hospital. References and full details of experience supplied. Apply Box 505E, The Canadian Hospital, 57 Bloor St. West, Toronto.

Registered Medical Record Librarian Wanted

As assistant in a large teaching Hospital in Toronto. Blue Cross and Pension Plan. Box No. 516S, The Canadian Hospital, 57 Bloor St. W., Toronto 5, Ontario.

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For Moncton Hospital, Moncton, N.B. (210 beds). Five dietitians on staff. Straight 8 hour-day. Please apply to Chief Dietitian.

Position Wanted

Accountant-office manager, experience in 85-bed hospital, requires position in hospital of similar or larger size: Apply Box 1013M, The Canadian Hospital, 57 Bloor St. West, Toronto, Ontario.

University of Alberta School of Nursing

The University of Alberta invites applications for the position of Director of School of Nursing.

Applications accompanied by a curriculum vitae transcripts of record, the names of at least three references, and a recent photograph or snapshot, should be received by the Dean of Medicine, University of Alberta, not later than June 30, 1956.

Radiologist's Services Required

The services of a certified Radiologist are required for a 60 bed hospital serving about 25,000 persons in the area. Staff of well qualified Doctors working at the Hospital. Every opportunity for the right applicant to expand the service. All applications confidential and will receive replies. Reply to Box 415Y, The Canadian Hospital, 57 Bloor St. W., Toronto, Ont.

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Applications are invited for the position of Director of Nursing: Hospital capacity 275 beds, 26 bassinets. This position would include overall supervision of nursing and nursing education; School of Nursing of 53 students.

Applications should be addressed to the Administrator, General Hospital of Port Arthur, Ont., stating qualifications, experience and salary requirements.

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New Hospital Council Organized in Saskatoon, Sask.

The three large general hospitals in the city of Saskatoon (St. Paul's, Saskatoon City, and the University Hospital), together with the Saskatoon Sanatorium and the Saskatoon Nursing Home, have organized a Saskatoon Hospital Council. Each hospital has at least two representatives, one from the hospital board and one representing the administrative staff. The new council is a formally constituted body representing the hospitals of Saskatoon for the exchange of ideas, for co-operative effort in certain defined areas and for improving administrative and educational techniques.

The first concrete joint effort on the part of the participating hospitals was a combined publicity and educational campaign for National Hospital Day and National Hospital Week this month. The program embraced radio and television announcements; a film on hospitals shown by the local television station; short programs by the nurses' glee clubs over radio and television; open house at two of the hospitals and special exhibits in the lobbies of two others.

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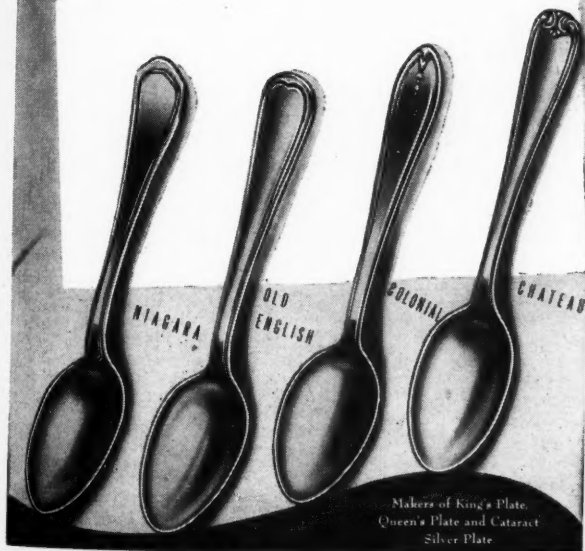
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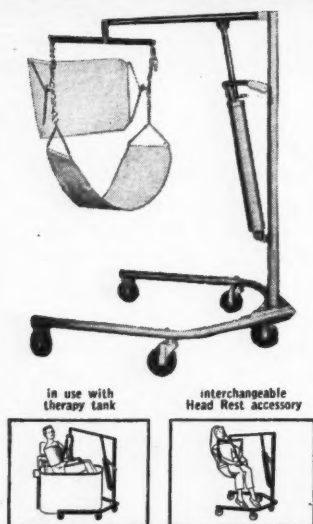
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Canadian Research Receives British Grant

The research program at McGill University, Montreal, has received from the Wellcome Trust of London, England, a grant of \$140,000 to support anaesthesia research at the University and its teaching hospitals. The Trust is headed by Sir Henry Dale, world-famous physiologist who attended the International Physiological Congress at McGill in the summer of 1954. Projects to be undertaken in the enlarged research program will include not only new anaesthetic drugs but

also new techniques. The grant will make possible the appointment of a full-time research professor of anaesthesia. Head of the department of anaesthesia at McGill is Dr. Harold Griffith, who is also anaesthetist-in-chief at the Queen Elizabeth Hospital and president of the World Federation of Societies of Anaesthetists. Dr. Griffith is widely known for his introduction into clinical use of the South American Indian arrowhead poison curare, used to secure a more complete relaxation of muscles in major operations.



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Morale Booster at Essondale

A new "Apparel Shop" at the Provincial Mental Hospital, Essondale, B.C., has been a success far beyond expectations. The volunteers from the Canadian Mental Health Association, who run it, first intended just to give clothes to patients who were ready to leave the hospital but the project had a surprising sequel. Now thirty patients in the worst ward of all have been outfitted with dresses, shoes, sweaters, skirts, suits, handbags, and costume jewelry, thereby picking up a thread of interest in life and a hope for recovery that they didn't have before. The shop is doing a constructive work in the program of mind-salvage so eagerly pursued by the doctors and nurses at Essondale.

Looking Ahead

The paradise we seek for old age is not a rocking chair in which to sit and twiddle our thumbs, but a place where we may use our strength and gifts and knowledge and experience to finish our job or to do other jobs for which we never had time. Activity in a useful role gives us a feeling of adequacy and accomplishment.

Our faces may be scribbled over with autobiographical notes that tell past hopes, fears, joys, angers and disappointments, but life always begins where we are. We should have a purpose; we should still want to do something; we should still look ahead expectantly.

Hobbies need not be merely past-times: they can be stimulating, enjoyable and remunerative, providing outlets for our creative impulses and our self-expression. They should be planned for and worked toward from our middle years, and at the proper period of our development they should be ready to step in to fill the vacancies in our lives. Said 87-year-old Frank Wise as he set up his exhibition of bookbinding at Montreal's first Golden Age Hobby Show this year: "I just haven't time to grow old".

And when Colonel Anderson, who at 91 was the dean of United States portrait artists, was asked: "What is your greatest picture?" he replied "I haven't painted it yet." — *The Royal Bank of Canada Monthly Letter, December, 1955.*

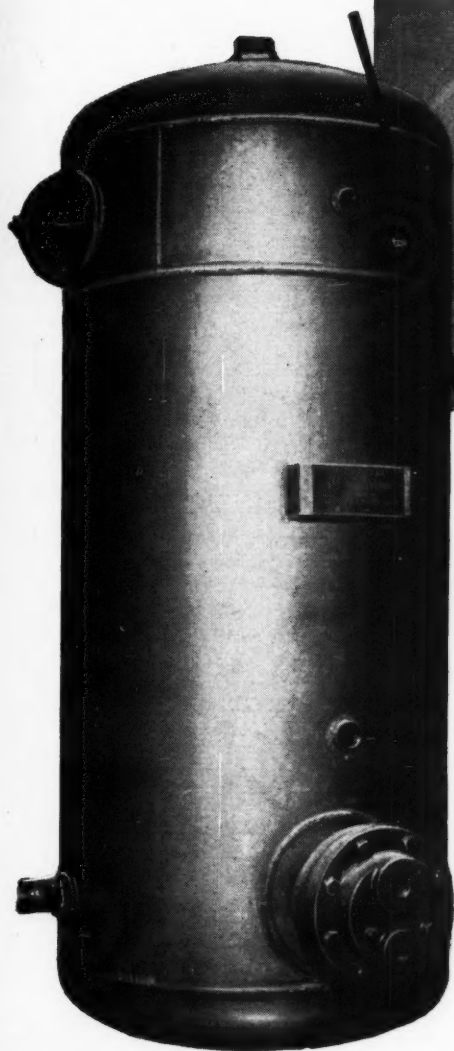
Words

Words may be the wings on which your lofty thoughts soar to rarified planes and vertiginous heights — or they may be the rickety crutches on which your spavined maunderings limp their sordid way through the clotted debris of the gutter. — *Mervyn J. Huston.*

The CANADIAN HOSPITAL

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... Across the Desk

News Released by Hospital Supply Houses

By C.A.E.

New Literature Available On Oxygen Administration

Procedure sheets giving brief instructions for operating some of the commonly-used oxygen administering apparatus are now available. They outline the purpose of the treatment, equipment needed, and correct administering techniques and give directions for the cleaning and storage of equipment after use. These sheets can be used as class notes for student nurses or kept as a handy reference at nursing stations throughout the hospital.

Instructions for meter masks, re-breathing masks, oropharyngeal catheters, and tents are completed and can be obtained free of charge from Linde Air Products Co., Oxygen Therapy Department, Toronto. Procedure sheets on plastic hoods and the various types of I.P.P.B. apparatus are being prepared and will be completed within the next few weeks.

Thermostatically Controlled Valves

When fitted to an under-water treatment bath, as shown in this illustration, a Leonard valve has two functions. Firstly, it enables the nurse to fill the bath rapidly with water at a suitable temperature; she does not have to waste time adding hot or cold water or get the temperature right after the bath has been filled. Secondly, to keep the water warm while the patient is in the bath, a small flow of water is run from the Leonard valve. As little as a gallon of water

a minute is enough to keep the temperature up.

The Leonard valve is mounted on the wall behind the bath within easy reach of the nurse or attendant. On the left hand side there is a shower fitted with a concealed Leonard Rada for use by the patient after the bath.



This photograph was taken in the Norah Francis Henderson Hospital in Hamilton, Ontario. Further particulars on Leonard Rada Thermostatically controlled valves available from Walker, Crossweller & Co. Limited, Cheltenham, Gloucestershire, England.

Incorporation of Dri-Heat Food System Ltd.

The firm of R. H. Venn and Co. announce that, as of 1st April, they discontinued business and trading under the old name, and incorporated under the new name of Dri-Heat Food System Limited, in Canada.

Mr. R. H. Venn, President of the new company, also announces that he has purchased the American Company, which formerly operated under the name of the Thermo Banquet Rings Co., and has changed that company's name to the Dri-Heat Food System Inc., 2607 Connecticut Avenue, N.W., Washington, D.C.

The new companies will continue to promote the Dri-Heat Hot Plate, and the subsidiary equipment, Pellet ovens and carts and thermal jugs, together with their other lines.

This comparatively new system of serving hot food is making rapid strides in Canada and within the next eighteen months a considerable number of hospitals throughout Canada will have centralized their food services around this system.

A new folder is presently being prepared illustrating their general line comprising the system, which assures serving of hot food. Anyone wishing to have copies may obtain same by writing the new company at 159 Jane Street, Toronto.

Floor Maintenance Products Introduced By Diversey

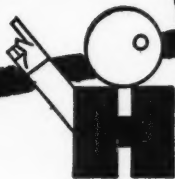
An important group of products in the hospital and industrial floor maintenance field have been introduced recently by the Diversey Corporation (Canada) Limited Port Credit. There are four products that comprise Diversey's industrial floor wax line—Diversey's Tile Gloss, Diversey Self-Polishing Floor Gloss, Diversey Paste Wax and Diversey Floor Cleaner. While the wax products are a new addition to Diversey's maintenance products division they have been thoroughly tested and proven in actual use under the heaviest traffic conditions. As a consequence, Diversey have selected the words "traffic tested" as a theme for supporting advertising and packaging design.

Diversey Tile Gloss is a liquid wax that is specially formulated to meet even the most rigid requirements of floor maintenance in hospitals, hotels, restaurants, offices, and, in fact, wherever heavy traffic conditions prevail. It is reported that Diversey Tile Gloss gives outstanding results when used on linoleum, rubber, asphalt and plastic tile floors. It is quick-drying—15 or 20 minutes—and an exceptionally high gloss can be obtained by only buffing lightly.

Diversey Self-Polishing Floor Gloss is manufactured particularly for those who favour a completely "self-polishing" wax. Here again, outstanding results are claimed on the same types of floors as listed above. Diversey Self-Polishing Floor Gloss is also a quick-drying product, but its particular advantage is that it requires no buffing.

Diversey Corporation claim as an outstanding factor the fact that both their Tile Gloss and Floor Gloss products will cover a floor area of 3,000 (Concluded on page 130)

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TF 181

ACROSS THE DESK

(Concluded from page 128)

square feet per gallon. This is exceptional coverage.

Diversey Paste Wax is stated to be one of the finest spirit-solvent-type waxes made. It is sold mainly for maintenance of hardwood floors and stands up extremely well under the heaviest traffic conditions. It has excellent water resistance, wear resistance, and has a long-lasting gloss, dries quickly and polishes readily to a high durable finish.

Diversey Paste Wax can also be used for linoleum, cork, concrete, and terrazzo floors.

Diversey point out that the floor cleaner has been exclusively formulated for removal of old waxes and dirt from all types of floors *except* cork and hardwood. It is recommended particularly for wax stripping and for light cleaning when a mild concentration is used. The floor cleaner is not to be used on hardwood floors.

Further information about Diversey's Floor Wax line of products can be obtained by writing the Diversey Corporation (Canada) Limited in Port Credit.

Joel R. Brown Now Lederle Manager

Joel R. Brown, Jr. has been appointed manager of Lederle Laboratories Division North American Cyanamid Limited, with headquarters in Montreal, it has been announced by F. S. Washburn, president.



Joel R. Brown

Mr. Brown replaces Austin W. Roche, who has accepted the position of director of foreign operations for the Fine Chemicals Division, American Cyanamid Company. Mr. Brown was formerly assistant domestic sales manager for Lederle in the United States, a position he held since 1954. He joined Lederle as a salesman in 1947 and became district manager of the Denver-Salt Lake City District,

Rocky Mountain Region, in 1950. In 1955 he was appointed assistant regional manager of the Metropolitan New York area.

Married and the father of two girls, Mr. Brown and his family will reside in Montreal.

Real St. Maurice Has New Post At B & B

The appointment of Real St. Maurice as district sales manager for Eastern Canada has been announced by J. D. Gwynne, general sales manager of Bauer & Black.



Real St. Maurice

Mr. St. Maurice was a sales representative in Montreal and Quebec for a number of years and then headed up a merchandising department in Toronto. Now, he and his wife and two children, return to Montreal where he will supervise Bauer & Black sales activities in hospitals and drug stores in the Ottawa Valley, Quebec and Maritimes.

Johnson Temperature Names Five To New Posts

Johnson Temperature Regulating Co. of Canada Limited has announced the following new staff appointments:

Balfour J. Horsburgh, manager of the Montreal branch, becomes eastern regional manager. His management responsibilities will continue to include the Montreal branch and will extend to other eastern offices including those at Halifax and Ottawa;

W. L. Rootham, manager of the Toronto branch, becomes assistant Canadian sales manager, with headquarters at the company's main office in Toronto;

Bruce Overend, formerly engineer in charge of the London, Ontario, branch, succeeds Rootham as Toronto manager;

Arthur Johnson of the Toronto branch, becomes engineer in charge at London;

Tom Patterson will supervise as-

sembly and manufacturing operations at the company's Toronto headquarters.

Both Horsburgh's and Rootham's positions are newly created as a result of the continued expansion of the company's manufacturing operations and nation-wide sales, engineering and contracting of automatic temperature and air conditioning control systems.

C. Guy Grace Heads Colgate-Palmolive in Canada

The career of C. Guy Grace, president of Colgate-Palmolive Limited in Canada, has been extremely interesting and varied.

Born in 1907, Mr. Grace joined the Colgate-Palmolive Company in 1929 after graduating from North Western University. Since that time, he has held a succession of increasingly important jobs. He has the distinction of having been appointed, at 32, the youngest general manager in the company's history. He has held positions with the Colgate-Palmolive Company in The British West Indies, Haiti and Colombia. An outstanding organizer, he now directs the operations of 1,000 Canadian employees from coast-to-coast. A strong believer in delegating authority, Mr. Grace inspires his management team to be forward thinking, deal in broad principles and have an unquestionable confidence in the future growth of Canada.

Mr. Grace resides in a spacious, modern home in suburban Willowdale.

On Sales Staff Of Mathews Conveyer

The Mathews Conveyer Company, Limited, Port Hope, Ontario, announces the appointment of W. W.



W. W. Ruppel

Ruppel to the sales staff of its Toronto office.

Mr. Ruppel has spent the past eight years on conveyer sales in conjunction with two other well-known conveyer manufacturers.

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